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RURAL HEALTH CARE DISPARITIES CREATED BY MEDICARE REGULATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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RURAL HEALTH CARE DISPARITIES CREATED BY MEDICARE REGULATIONS

TUESDAY, JULY 28, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The Subcommittee met, pursuant to call, at 10:06 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady [chairman of the subcommittee] presiding.

[The advisory announcing the hearing follows:]

Chairman Brady Announces Rural Health Hearing

Congressman Kevin Brady (R-TX), Chairman of the Subcommittee on Health, today announced that the subcommittee will hold a hearing to discuss rural health care disparities created by Medicare regulations. **The hearing will take place on Tuesday, July 28, 2015 in 1100 Longworth House Office Building, beginning at 10:00 A.M.**

Oral testimony at this hearing will be from the invited witness only. However, any individual or organization may submit a written statement for consideration by the committee and for inclusion in the printed record of the hearing.

Details for Submission of Written Comments:
Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the committee website and complete the informational forms. From the committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, August 11 2015**. For questions, or if you encounter technical problems, please call (202) 225-3625 or (202) 225-2610.

Formatting Requirements:
The committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the committee. The committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the committee files for review and use by the committee.

1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the committee relies on electronic submissions for printing the official hearing record.
2. All submissions must include a list of all clients, persons and/or organizations on

whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the committee as noted above.

Note: All committee advisories and news releases are available at http://www.waysandmeans.house.gov/.

Chairman BRADY. Good morning. Welcome to today's hearing to discuss rural healthcare disparities created by Medicare regulations. This is an important issue for all, but the challenges facing beneficiaries and providers are especially evident to those of us who represent districts that aren't completely urban.

Our constituents are seeing firsthand the difficulties caused by overregulation and bureaucracy. And it's our rural neighbors who pay the price when it comes to access. Take, for instance, the so-called 96-hour rule. Critical Access Hospitals are a critical piece of rural health infrastructure. Doctors at Critical Access Hospitals have to certify that it is reasonable that an individual be discharged and transferred to a hospital within 96 hours of being admitted to a Critical Access Hospital. That arbitrary cutoff doesn't always match the medical reality for patients seeking treatment at facilities near their homes. I personally heard from St. Joseph's, a Critical Access Hospital in my district, on the problems with the 96-hour rule.

Or consider the rules related to physician supervision: Physician shortages are a reality in many parts of our country. Rules that change the way routine therapeutic services are handled in rural areas or rules that bar physician assistants from providing services, like hospice, disrupt access and the continuity of care for rural beneficiaries.

We can do better. We must do better. We will do better. We should provide relief for all of our hospitals and providers from overly burdensome regulations in bureaucracy. There is no better place to start that process than with our rural hospitals. There is much to be done, and today we are lucky to have here firsthand accounts from providers serving rural communities. First, we have Shannon Sorensen, CEO of Brown County Hospital in the Ainsworth, Nebraska, a constituent of Mr. Smith. Next, we have Tim Joslin, the CEO of Community Regional Medical Centers in Fresno, California, a constituent of Mr. Nunes'. Then we have Carrie Saia, the CEO of Holton Community Hospital, a facility in Congresswoman Jenkins' hometown in Kansas. Finally, we have Dr. Daniel Derksen from the University of Arizona.

We are very happy to have you here today.

This is the latest in a series of hearings held by the Health Subcommittee in the wake of the passage of legislation to fix the way Medicare pays our Nation's physicians. Now, I know we mentioned this in our MedPAC hearing last week, but it stands repeating: We are in the midst a great opportunity to reform how Medicare reimburses hospitals and post-acute-care providers, all critical to saving Medicare for the long term.

I hope today we can make progress in understanding the concerns facing those in rural areas.

And before I recognize the ranking member, Dr. McDermott, for the purpose of an opening statement, I ask unanimous consent that all members' written statements be included in the record.

Without objection, so ordered.

I now recognize Dr. McDermott for his opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I want to thank the witnesses for coming this morning. I look forward to hearing what you have to say. I believe there is room for

us to work together to address how we deliver health care to people who live in rural areas. I also believe that if we are going to have a serious conversation about this topic, we need to get the facts straight. Time and time again, I hear from Republican colleagues about rural hospitals closing down, threatening access to health care for many communities.

I happen to represent an area where we have the WWAMI program, which covers one quarter of the United States' land mass, so I know about rural areas. And as they do with virtually every perceived problem in the healthcare system, my colleagues place the blame for all of it squarely on the Affordable Care Act. There is another side to this story.

One of the major financial strains placed on hospitals is uncompensated care—has been for years. When patients, many of whom are poor and quite sick, are not covered by insurance and cannot afford to pay out of pocket, hospitals have to pick up the cost. It has been true—and we have not had the ability in the law yet to say you don't have got to take care of somebody. So if somebody comes in, you have to take care of them. And somebody pays; it is the hospital.

We recognized this problem when we passed the Affordable Care Act. We worked to reduce uncompensated care coverage—dramatically through an expansion of coverage of Medicaid. This would provide some of the more economically or most economically vulnerable people, many living in rural underserved areas with access to coverage.

However, under Republican leadership, more than 20 States—20 States—refused simply to accept Medicaid expansion, simply because it was part of President Obama's Affordable Care Act. Their decision has left 4.3 million people without insurance, forcing hospitals, many of them which serve rural areas, to pick up the cost. And not coincidentally, 80 percent of the hospitals that have announced recent closures are in States that chose not to expand Medicaid—80 percent are in States that didn't expand Medicaid. This is not a problem of Medicare regulations governing rural hospitals, nor is it a problem with the Affordable Care Act. It is a problem with the party that would prefer to sabotage the President's healthcare program for political purposes rather than try to make it work.

So if we want to improve access to rural care and address the issue of rural hospital closures, we have to start by convincing the leadership to do what they should have done in the first place and expand Medicaid. To address the needs of rural communities, we also need to have long-term investments in our professional workforce.

The United States faces a growing shortage of physicians and healthcare providers. That is nurse practitioners, PAs, all the people that provide care in rural ares. And it is predicted to reach in physicians alone by 2025 between 46,000 and 91,000 people short to provide what is necessary. Rural areas are going to have a particular scarcity of physicians. We have tried lots and lots of things in the WWAMI program, but we continue to run into some of the same problems.

Now, we should be skeptical that the solution of the problem lies in gutting Medicare support for graduate medical education in urban areas. There is minimal evidence whatsoever that this will result in more doctors practicing in rural areas. It will simply exacerbate the nationwide doctor shortage and lower the quality of training. There are better ways to train physicians who serve in rural areas. I encourage my colleagues to look at some alternatives.

The University of Washington has run the WWAMI program, as I mentioned, which trains physicians not only in the cities but out in the rural areas. They are placed out in little bitty places, and they see what it is like. And they learn what is necessary, but also getting them to stay is tough. The program is the finest in primary care and rural in the whole country and has ably served the communities in Washington, Wyoming, Alaska, Montana, Idaho, for more than four decades.

There are some other investments I believe we have to make if we are really going to deal with rural access. We can treat the medical profession like we treat the armed services and provide ROTC-style medical school scholarships to doctors who agree to a tour of service in underserved areas. I call this RDOCS, and I believe it is a smart investment. We don't think there is anything wrong with giving somebody a college education and then keeping him in the Navy or the Army or the Air Force for 5 years. Why don't we do the same thing with medicine? Get somebody to sign a contract upfront: I will take the scholarship, but I will serve 5 years as a result of that. Now, that is the only way you are going to get people out there for a long enough period for them to decide, you know, maybe I want to stay here. That is the real problem.

Moving forward, rather than attacking our existing programs and pitting urban areas against rural areas, as we are going to do with this GME and IME and all the rest of it, I invite my colleagues to consider alternatives that would make a meaningful difference in rural areas.

I yield back the balance of my time.

Chairman BRADY. Thank you, Dr. McDermott.

We are really excited to have the witnesses today. We think there is some common ground on areas like this that we can move forward on.

So, Mr. Joslin, you are recognized for 5 minutes.

STATEMENT OF TIM JOSLIN, CEO, COMMUNITY REGIONAL MEDICAL CENTERS, FRESNO, CA

Mr. JOSLIN. Thank you, Mr. Chairman, Ranking Member McDermott, and Members of the Subcommittee. My name is Tim Joslin, and I am the chief executive officer of Community Medical Centers, based in Fresno, California. I appreciate the invitation to testify today about rural healthcare disparities and the role of federally funded graduate medical education, known as GME.

Community Medical Centers is the largest healthcare provider in California's agricultural heart, San Joaquin Valley. We are a not-for-profit public-benefit operation operating four hospitals: Community Regional Medical Center in Fresno; Clovis Community Medical Center; Fresno Heart & Surgical Hospital; and Community Behav-

ioral Health Center. Community Medical Centers accounts for one-third of all inpatient discharges in the five-county region.

We run a level 1 trauma center, a burn center, and an ambulatory care center. We are also the largest inpatient provider of Medi-Cal services and uncompensated care in the region. Our downtown Fresno emergency department is one of the busiest in the State with some 114,000 visits a year. We provide all of this with the help of about 300 medical residents and fellows from the UCSF School of Medicine.

Our challenge is unique and daunting. The rural San Joaquin Valley, though rich agriculturally, is very poor economically. Twenty-five percent of residents live in areas of concentrated poverty, making it the fifth poorest area in the country. In Fresno County alone, one-third of all children live at our below the poverty level. About 20 percent of Fresno County residents do not speak English and one-third of adults have not obtained a high school diploma. The entire area's population has significantly higher than average rates of asthma, diabetes, and obesity. Nearly one-third of the population qualifies as obese, for example. The Valley also has a higher than average incidence of chronic lung disease, likely due to is well-documented air quality issues.

To make these sobering statistics even worse, the San Joaquin Valley suffers from a doctor shortage. The Valley has 48 primary care physicians per 100,000 residents, well below the minimum recommended level of 60. If need is the measure, our region of the country should have more physicians per capita, not fewer. Graduate medical education is the key to solving this inequity. Community Medical Centers collaborates with the University of California San Francisco to support the training of graduate medical students. We currently support some 250 medical residents studying in eight areas, including primary care and emergency medicine. And we support 50 fellows studying in 17 medical subspecialties. This GME program is a critical feeder to the region's entire physician population, and we would like to grow the program.

We are constrained, however. Our Medicare funding for GME positions is frozen at 1997 level. Community Medical Centers has expanded the program on its own beyond what Medicare funds by investing well over $400 million over the last 10 years, but considering that Community Medical Centers now shoulders more than $180 million in uncompensated care each year, the ability to expand our GME program on our own is financially limited. This in turn limits our ability to provide our region's residents access to health care now and in the future.

In a region where the need for physicians is perhaps the greatest in the country, we are at a disadvantage under the current Federal system of allocating GME slots, yet our ability to expand access to physicians is highly dependent upon the GME program. As the Institute of Medicine's recent report noted, the location of one's medical school and GME training are predictive of practice location. Our own experience shows this. Close to 30 percent of our trained residents remain in the region to practice medicine. The current GME allocation criteria and caps have led to significant geographic disparities, as noted in a recent health affairs report, and are most acutely felt in our region of California.

For example, our region's population has increased by a third since 1997, yet our federally funded resident physicians have remained at the 1997 level. This contributes to the disparity we see in the ratio of physicians to population. Community Medical Centers supports not only the expansion of GME but, equally critical, better allocation of GME slots to underserved regions within a State. We believe that policy goals of federally funded GME would be better served by a revised allocation system and urge this committee to consider proposals. We believe this will directly lead to more efficient and effective health care in our rural underserved region.

Thank you again for this opportunity.

[The prepared statement of Mr. Joslin follows:]

STATEMENT OF TIM JOSLIN
CEO, Community Medical Center
Before the
United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

July 28, 2015

Mr. Chairman, Ranking Member McDermott, and members of the Subcommittee, my name is Tim Joslin and I am the Chief Executive Officer of the Community Medical Centers based in Fresno, California. I appreciate the invitation to testify today about rural health care disparities and the role of federally funded graduate medical education, known as GME.

Community Medical Centers is the largest health care provider in California's agricultural heart, the San Joaquin Valley. We are a not-for-profit, public benefit corporation operating four hospitals — Community Regional Medical Center in Fresno, Clovis Community Medical Center, Fresno Heart and Surgical Hospital, and Community Behavioral Health Center. Community Medical Centers accounts for one-third of all inpatient discharges in the five-county region. We run a

level-1 trauma center, a burn center, and an ambulatory care center. We are also the largest provider of inpatient Medi-Cal services and uncompensated care in the region. Our downtown Fresno emergency department is the one of the busiest in the state, with some 114,000 visits a year. We provide all this with the help of about 300 medical residents and fellows from the UCSF School of Medicine.

But our challenge is unique, and daunting. The rural San Joaquin Valley, though rich agriculturally, is very poor economically. Twenty-five percent of residents live in areas of concentrated poverty, making it the 5th poorest area in the country. In Fresno County alone, one-third of all children live at or below the poverty level. About 20% of Fresno County residents do not speak English, and one-third of adults have not obtained a high school diploma. The entire area's population has significantly higher than average rates of asthma, diabetes and obesity. Nearly one-third of the population qualifies as obese, for example. The Valley also has a higher than average incidence of chronic lung disease, likely due to its well-documented air quality issues.

To make these sobering statistics even worse, the San Joaquin Valley suffers from a doctor shortage. The Valley has 48 primary care physicians per hundred-thousand residents, well below the minimum recommended level of 60.

If need is the measure, our region of the country should have more physicians per capita, not fewer. Graduate medical education is the key to solving this inequity.

Community Medical collaborates with the University of California San Francisco to support the training of graduate medical students. We currently support some 250 medical residents studying in eight areas, including primary care and emergency medicine. And we support 50 fellows studying in 17 medical sub-specialties. This GME program is a critical feeder to the region's entire physician population, and we'd like to grow the program.

We are constrained, however. Our Medicare funding for GME positions is frozen at a 1997 level. Community Medical Centers has expanded the program on its own — beyond what Medicare funds — by investing well

over $400 million over the last 10 years. But considering that Community Medical Centers now shoulders more than $180 million in uncompensated care each year, the ability to expand our GME program on our own is financially limited. And this, in turn, limits our ability to provide our region's residents access to health care now and in the future.

In a region where the need for physicians is perhaps the greatest in the Country, we are at a disadvantage under the current federal system of allocating GME slots. Yet our ability to expand access to physicians is highly dependent upon the GME program. As the Institute of Medicine's recent report noted, "The location of one's medical school and GME training are predictive of practice location." Our own experience shows this. Close to 30% of our trained residents remain in the region to practice medicine.

The current GME allocation criteria and caps have led to significant geographic disparities, as noted in a recent Health Affairs report, and are most acutely felt in our region of California. For example, our region's population has increased by a third since 1997, yet our

federally funded resident positions have remained at the 1997 level. This contributes to the disparity we see in the ratio of physicians to population.

Community Medical Centers supports not only the expansion of GME, but equally critical, better allocation of GME slots to underserved regions within a state. We believe the policy goals of federally funded GME would be better served by a revised allocation system and urge this Committee to consider proposals. We believe this will directly lead to more efficient and effective health care in our rural, underserved region.

Thank you again for this opportunity.

Chairman BRADY. Thank you, Mr. Joslin.

Ms. Sorensen, you are recognized for 5 minutes.

STATEMENT OF SHANNON SORENSEN, CEO, BROWN COUNTY HOSPITAL, AINSWORTH, NEBRASKA

Ms. SORENSEN. Good morning, my name is Shannon Sorensen. I am the CEO of Brown County Hospital, a Critical Access Hospital located in north central Nebraska. I would like to thank Chairman Brady, Ranking Member McDermott, and the members of the House Ways and Means Subcommittee on Health for holding this hearing.

Approximately one in six Americans live in rural areas and depend on the hospital in their communities. We are exactly one of those facilities. Not only does our location, being over 150 miles from the nearest tertiary facility, affect us, our patient mix being over 70 percent Medicare also makes us more reliant on public programs. Changes, such as the 96-hour rule, often have significant and problematic consequences for rural providers.

Due to the great support of our local community, compared to many of my peers, our hospital's financial situation is stable, but we are especially vulnerable to Medicare and Medicaid payment cuts. We are the communities and hospitals that most need your help.

The 96-hour rule is especially burdensome in our day-to-day mission of providing health care in our communities. From the creation of CAH designation, until late 2013, an annual average of 96-hour stays allowed CAH's flexibility within the regulatory framework set up for the designation.

The new policy of strict enforcement of a per-stay 96-hour cap creates an unnecessary red tape. Not only does it potentially limit access to health care by forcing rural beneficiaries to travel farther for treatment, it may deter them from necessary care, inconvenience patients, and add travel costs to Medicare. It impedes rural providers in their ability to care for their patients. Having to focus on regulatory burdens interferes with the best judgment of physicians and other healthcare providers, placing them in a position where our providers are constantly making regulatory decisions to dictate the medical decisions they need to make. The 96-hour condition of payment leaves no room for a needed change in the medical care plan if treatment does not go as anticipated.

It is also important to note that while we must maintain an annual average length of stay of 96 hours, we offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force us to eliminate these 96-hour-plus services and cause financial pressures that will severely affect our ability to operate. These are important services in our community and allow patients to get needed services and recover around their family and friends.

CAHs in Nebraska and across the country support the Critical Access Hospital Relief Act, which would remove the 96-hour condition of payment. I especially want to thank my Representative, Congressman Smith, for introducing the important legislation. Rural facilities and providers face many challenges without the

heavy hand of government. We must be given the flexibility to provide affordable and efficient health care.

Another burdensome regulation is the expansion of mandatory direct physician supervision. We simply do not have the manpower and resources to abide by these arbitrary regulations. Our highly trained licensed personnel are not able to practice at the highest level of their scope with this regulation.

For 2015 and beyond, the agency requires a minimum of direct supervision for all outpatient therapeutic services furnished in our Critical Access Hospital, unless it is on the list of services that may be furnished under general supervision or is designated as nonsurgical extended duration therapeutic service.

We are deeply disappointed that CMS did not heed concerns that this policy will be difficult to implement, will reduce access, and is clinically unnecessary. CAHs and small rural hospitals support the adoption of the default standard of general supervision, consistent definition of direct supervision, and prohibiting enforcement of CMS' retroactive reinterpretation back to 2001.

H.R. 170 delays the unnecessary and burdensome physician supervision regulations and requires CMS to study their impact. We already face many unique challenges, such as providing quality care with more limited resources; satisfying complicated administrative requirements with a smaller staff; complying with numerous Federal regulations, which limit the discretion of highly trained providers; and now to be located in the building to render these services.

Our community has one full-time primary care physician who is supported by two mid-level providers. With some of the regulatory burdens we face—such as requiring only a physician to oversee cardiac rehab or only a physician being able to order durable medical equipment, home health, or hospice services—any time our lone physician is not on our campus, takes vacation, or attends continuing education, significant patient needs have to wait.

Our very capable mid-levels are able to provide the needed services in our emergency room and throughout the hospital. It makes no sense to prevent them from being able to do the same for cardiac rehabilitation, outpatient therapeutic services or other necessary services.

Medicare provides vital funding for many rural payment programs, including Critical Access Hospitals. This subcommittee and Congress has the power to ensure Americans living in rural America who depend on the hospital will have access to appropriate care.

Again, thank you, Congressman Smith, for introducing H.R. 169. We appreciate the subcommittee's interest in the matter and urge it and the Congress to support much needed legislation. Thank you for your time and listening to our impact.

[The prepared statement of Ms. Sorensen follows:]

****TESTIMONY IS EMBARGOED UNTIL START OF THE HEARING: 10 AM, JULY 28, 2015****

Brown County Hospital
945 East Zero Street * Ainsworth, NE 69210 * 402-387-2800
www.browncountyhospital.org

***TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING
AT 10:00 AM TUESDAY JULY 28, 2015***

Testimony of Shannon Sorensen, Chief Executive Officer
Brown County Hospital, Ainsworth, Nebraska on behalf of
Brown County Hospital and the Nebraska Hospital Association
House Committee on Ways and Means
Subcommittee on Health

July 28, 2015

Good morning, my name is Shannon Sorensen. I am the CEO of Brown County Hospital, a critical access hospital (CAH) located in north central Nebraska. I would like to thank Chairman Brady, Ranking Member McDermott, and the members of the House Ways and Means Subcommittee on Health for holding this hearing.

Approximately one in every six Americans lives in rural areas and depends on the hospital in their communities. Remote location, small size, limited workforce, physician shortages and often strained financial situations pose unique challenges for rural hospitals. Not only does our location, being over 150 miles from the nearest tertiary facility affect us, our patient mix being over 70% Medicare also makes us more reliant on public programs. Changes such as the "96 Hour Rule" often have significant and problematic consequences for rural providers.

Due to the great support of our local community, compared to many of my peers, our hospital's financial situation is stable, but we are particularly vulnerable to Medicare and Medicaid payment cuts. Furthermore, many of my colleagues are struggling. Currently 38% of CAHs have a negative operating margin. CAHs make up nearly 30% of acute care hospitals, but receive less than 5% of total Medicare payments to hospitals. CMS actually spends 2.5% less on rural beneficiaries than it does on urban beneficiaries. Unfortunately, the hospitals and communities in dire straits are too absorbed in their struggles to keep their doors open to reach out to their members of Congress or to come and testify like I am doing today. We are the communities and hospitals that most need your help.

96 Hour Rule. Recent CMS guidance, in relation to its two-midnight admissions policy, implies that the agency will begin enforcing a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. If the provider cannot certify this, the hospital either must transfer the patient or face non-reimbursement. This requirement adds one more unnecessary burden on our rural facility, others like it and the Medicare beneficiaries who already must travel long distances for treatment. From the creation of the CAH designation until

late 2013 an annual average of 96 hour stays allowed CAHs flexibility within the regulatory framework set up for the designation. The new policy of strict enforcement of a per stay 96 hour cap creates unnecessary red-tape. Not only does it potentially limit access to health care by forcing rural beneficiaries to travel even farther for treatment, it may deter many from seeking necessary care, inconvenience patients and add travel costs to Medicare. This enforcement eliminates important flexibility to allow general surgical services well suited for our high quality local providers to be able to perform needed and necessary procedures. It also impedes rural providers in their ability to care for their patients. Having to focus on regulatory burdens interferes with the best judgment of physicians and other health care providers, placing them in a position where highly qualified local providers cannot provide care for their patients.

It is also important to note, that while CAHs must maintain an annual average length of stay of 96 hours, they offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force CAHs to eliminate those "96 hour plus" services and cause financial pressures that will severely affect our ability to operate. Ultimately, access to care for beneficiaries in rural communities will diminish.

CAHs in Nebraska and across the country support the Critical Access Hospital Relief Act (H.R. 169/S. 258), which would remove the 96 hour condition of payment. I am especially pleased to thank my representative, Congressman Smith, for introducing this important legislation. Rural facilities and providers face many challenges without the heavy hand of government. We must be given the flexibility to provide affordable and efficient health care.

Physician Supervision. Another burdensome regulation is the expansion of mandatory direct physician supervision. Physician supervision rules require a physician's presence and direct supervision over nearly all routine procedures administered in hospitals. While physician supervision requirements are less of a challenge for large hospitals, they can be very problematic in areas with few doctors. CAHs simply do not have the manpower and resources to abide by these arbitrary regulations. Nor does this regulation allow all of our licensed personnel to perform within the highest level of their scope of practice.

The Centers for Medicare and Medicaid Services (CMS) previously delayed enforcement of physician supervision for CAHs as did Congress through 2014. CMS recently removed its moratorium on Medicare contractors enforcing its policies related to its "direct supervision" requirement of outpatient therapeutic services furnished in CAHs and small rural hospitals with 100 or fewer beds.

For 2015 and beyond, the agency requires a minimum of direct supervision for all outpatient therapeutic services furnished in small rural hospitals and CAHs, unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service. CAHs and small rural hospitals are deeply disappointed that CMS did not heed their concerns that this policy will be difficult to implement, will reduce access and is clinically unnecessary. CAHs and small rural hospitals support:

- Adoption of a default standard of "general supervision" for outpatient therapeutic services, supplemented with a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision;
- Assurance that, for CAHs, the definition of "direct supervision" is consistent with the CAH conditions of participation that allow a physician or non-physician practitioner to present within 30 minutes of being called; and
- Prohibiting enforcement of CMS's retroactive reinterpretation that the "direct supervision" requirements applied to services furnished since Jan. 1, 2001.

H.R. 170 delays the unnecessary and burdensome physician supervision regulations and requires CMS to study their impact. CAHs already face many unique challenges such as providing quality care with more limited resources, satisfying complicated administrative requirements with a smaller staff, complying with numerous federal regulations which limit the discretion of highly trained providers that provide lifesaving services to some of our most elderly rural populations.

Our community has one full-time primary care physician who is supported by two mid-level providers. With some of the regulatory burdens we face such as requiring only a physician to oversee cardiac rehab, or only a physician being able to order durable medical equipment, home health or hospice services, anytime our lone physician is not on our campus, significant patient needs have to wait. Our very capable mid-levels are able to provide the needed services in our emergency room and throughout the hospital. It makes no sense to prevent them from being able to do the same for cardiac rehabilitation outpatient therapeutic services.

Electronic Health Records (EHRs) and Meaningful Use. CAHS and small rural hospitals continue to be concerned about the impact of the EHR incentive program on CAHs and small rural providers. Specifically, this program should close, not widen, the existing digital divide. Yet, CMS data indicates that CAHs, in particular, have found it more challenging to meet meaningful use requirements than their urban counterparts, partly due to limited vendor choice and capacity. While the impact of the incentive has been a positive experience for us, we are struggling with an older population which has less access to computers; consequently making it difficult to meet Meaningful Use requirements for the patient portal.

Two-Midnight/Patient Status. Whether a patient is admitted to a hospital as an inpatient or treated under outpatient observation status has implications for Medicare payment and Medicare beneficiary coverage. Traditionally, the decision to admit a patient as an inpatient has been up to the judgment of the treating physician, with oversight from the hospital and input from the patient. CMS recovery audit contractors (RACs) and Medicare administrative contractors (MACs) have repeatedly second guessed physician judgment, declaring that some patients who were admitted should not have been. This has, in turn, created ambiguity over who decides what constitutes an appropriate admission and what the criteria are for making such a determination.

In an effort to clarify that ambiguity, CMS addressed the issue of patient status in the FY 2014 inpatient PPS final rule and finalized its "two-midnight" policy whereby the agency will generally consider hospital admissions spanning two midnights as appropriate for payment under

the inpatient PPS. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. Unfortunately, that effort added more pressure to an already stressed financial situation for most CAHs. In addition, it creates more expenses for our Medicare beneficiaries who are already on fixed incomes.

Recovery Audit Contractors (RACs). The RAC program needs to be reformed to realign the financial incentives that drive RACs to inappropriately deny claims. Payment structure for RACs should be changed from the current 9-12.5 percent commission on every denied claim to a retainer that does not incent them to deny claims. To ensure auditing accuracy, RACs should be assessed financial penalties for poor performance. The one-year timely filing limit to rebill outpatient (Part B) claims should be eliminated, which would allow hospitals to request outpatient payment for certain denied inpatient claims. RACs should only be able to consider the medical information that is available when a patient is seen by his or her physician when determining whether an inpatient stay was necessary. Our staff spend many laborious hours submitting appeals with additional supporting documentation to defend claims that were clearly appropriate and necessary.

Conclusion. Medicare provides vital funding for many rural payment programs including the critical access hospital (CAH), sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) programs. This subcommittee and Congress has the power to ensure that Americans living in rural areas who depend on the hospital in their communities will have access to the appropriate care they need by removing the heavy hand of government. Again, I want to thank Congressman Smith for introducing H.R. 169. We appreciate the Subcommittee's interest in this matter and urge it and Congress to support this much needed legislation. Thank you for your time and listening to our impact.

Chairman BRADY. Great, thank you.

Ms. Saia, you are recognized for 5 minutes.

STATEMENT OF CARRIE SAIA, CEO, HOLTON COMMUNITY HOSPITAL, HOLTON, KANSAS

Ms. SAIA. Good morning, Mr. Chairman, and Members of the Subcommittee, thank for the opportunity to speak today.

More than 36 percent of all Kansans live in rural areas and depend on the local hospitals serving their community. Rural hospitals face a unique set of challenges because of our remote geographic location, small size, scarce workforce, physician shortages, higher percentage of Medicare and Medicaid patients, and constrained financial resources with limited access to capital.

These challenges alone would make it difficult for many rural hospitals to survive. However, the increasingly burdensome Federal regulations that are being placed on healthcare providers make it difficult to budget, plan, and adequately prepare for the future.

Today, I would briefly like to share some challenges specifically related to the Medicare policy on direct supervision of outpatient therapeutic services and the 96-hour physician certification requirement.

First, I want to highlight the impact of Centers for Medicare and Medicaid policy for direct supervision about patient therapeutic services. This requires that a supervising physician be physically present in a department at all times when Medicare beneficiaries receive these services. This policy places additional unnecessary financial burden on my organization. Holton Community Hospital is staffed similarly to many rural hospitals across the Nation. Many have either a mid-level provider staffing their hospital with a physician available for supervision or a physician readily available within 30 minutes response time.

Staffing a physician onsite, as required by the regulations, will either result in changing our organizations then profitable bottom line into a negative bottom line or restrict the ability for us to be able to provide those services to our beneficiaries in our community.

One example of an outpatient therapy service that is a significant impact to our beneficiaries is the ability to offer intravenous infusions on an outpatient basis. There is a growing need for this service throughout our community. Due to a noted increase in the last couple of fiscal years, 2013 and 2015, this volume grew by over 22 percent. Not being able to provide this in our community and having the beneficiaries travel outside the community to receive this treatment would ultimately result in the beneficiary—a cost to them as well.

I strongly encourage this committee to extend the enforcement delay on direct supervision requirements for outpatient therapeutic services provided in Critical Access Hospitals for calendar year 2015. I strongly encourage the committee to work to pass H.R. 2878, as well as legislation that would address this problem on a more permanent basis.

A second area I would like to highlight today is the 96-hour physician certification requirement related to the Medicare condition of participation on the length of stay for Critical Access Hospitals.

The current Medicare condition of participation requires Critical Access Hospitals to provide acute inpatient care for a period that does not exceed on an annual basis 96 hours per patient.

In contrast, the Medicare condition of payment for Critical Access Hospital requires a physician to certify that a beneficiary may reasonably be expected to be discharged within 96 hours after admission to the hospital. As a rural hospital administrator, I can say with certainty that the discrepancies between the conditions of participation and the conditions of payment have caused nothing but confusion and challenges for Critical Access Hospitals.

This regulation also impedes the ability of the person who knows the patient best—the physician and other healthcare providers—and may unnecessarily cause patients to leave the community from which they live to receive care. I urge Congress to pass the Critical Access Relief Act, H.R. 169, introduced by Representative Adrian Smith, Lynn Jenkins, Todd Young and Dave Loebsack. This legislation would remove the Medicare condition of payment that requires a physician to certify that a patient is reasonably expected to be transferred or released within 96 hours but would leave in place the Medicare condition of participation requiring Critical Access Hospitals to maintain an average annual length of stay of 96 hours or less.

On behalf of my organization and similar rural organizations across the States of our Nation, I want to reinforce that it is critically important that our communities are able to access quality healthcare services. Too often, increasing and unwarranted Federal regulation burdens add additional challenges to providers with already constrained resources. As I highlighted in my written testimony, I have many examples of great outcomes that beneficiaries receive due to the ability to access care in a timely fashion. I am honored to join you today to discuss the action Congress can take to address rural healthcare disparities created by Medicare regulations. I would be happy to answer questions.

[The prepared statement of Ms. Saia follows:]

****TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING AT 10 AM, JULY 28, 2015****

Holton Community Hospital
Family Practice Associates

HOLTON COMMUNITY HOSPITAL
1110 Columbine Drive, Holton, KS 66436 • 785-364-2116
FAMILY PRACTICE ASSOCIATES – HOLTON
1100 Columbine Drive, Holton, KS 66436 • 785-364-2126
FAMILY PRACTICE ASSOCIATES – HOYT
207 Highland, Hoyt, KS 66440 • 785-986-6630
FAMILY PRACTICE ASSOCIATES – WETMORE
323 2nd St, Wetmore, KS 66550 • 785-866-4775

TO: House Committee on Ways and Means Subcommittee on Health

FROM: Carrie Saia, CEO

DATE: July 26th, 2015

RE: Challenges Facing Rural Health Care Providers

Mr. Chairman and Members of the Subcommittee,

Thank you for the opportunity to speak to you today. My name is Carrie Saia. I serve as the chief executive officer for Holton Community Hospital in Holton, Kansas. Our hospital is located Jackson County, which encompasses more than 656 square miles northeast Kansas and has a population of approximately 13,500 residents. Our organization, established in 1938, is a 12-bed Critical Access Hospital with three Rural Health Clinics. We employ approximately 140 individuals and operate solely based on income from services provided without revenues generated from mill levies, city or county tax dollars.

I am fortunate and proud to work in a rural community hospital whose employees strive to provide quality and efficient care to the members of their community with whom they live and work. More than 36 percent of all Kansans live in rural areas and depend on the local hospital serving their community. Rural hospitals face a unique set of challenges because of our remote geographic location, small size, scarce workforce, physician shortages, higher percentage of Medicare and Medicaid patients, and constrained financial resources with limited access to capital. These challenges alone would make it difficult for many rural hospitals to survive. However, the increasingly burdensome federal regulations that are being placed on health care providers make it difficult to budget, plan and adequately prepare for the future. I would like to briefly share some of the challenges specifically related to the Medicare policy on direct supervision of outpatient therapeutic services and the 96-hour physician certification requirement.

In 2009, the Centers for Medicare and Medicaid Services issued a new policy for "direct supervision" of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. In essence, the new policy requires that a supervising physician be physically present in the department at all times when Medicare beneficiaries receive outpatient

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Holton Community Hospital
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HOLTON COMMUNITY HOSPITAL
1110 Columbine Drive, Holton, KS 66436 • 785-364-2116
FAMILY PRACTICE ASSOCIATES – HOLTON
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FAMILY PRACTICE ASSOCIATES – HOYT
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FAMILY PRACTICE ASSOCIATES – WETMORE
323 2nd St. Wetmore, KS 66550 • 785-866-4775

therapeutic services. As a result, my organization like many others, has found itself at increased risk for unwarranted enforcement actions. While the Congressional action last year to delay enforcement was applauded by rural hospitals across the nation, there is now an urgency to either permanently fix this unnecessary set of regulations or at very least delay the enforcement until resolution can be met. Congress can provide both immediate and permanent relief from this burdensome regulation by passing legislation. I urge you to consider H.R. 2878, introduced by Representative Lynn Jenkins and David Loebsack. This important legislation would provide immediate relief from the burdensome direct supervision regulation by delaying its enforcement through calendar year 2015 for critical access hospitals and small and rural hospitals.

Holton Community Hospital is staffed similarly to many rural hospitals across the nation. Many have either mid-level providers staffing their hospitals with a physician available for supervision, or a physician readily available (within a 30 minute response time). Staffing a physician on-site as required by the regulations will either result in changing our organization's thin profitable bottom line into a negative bottom line, or restrict the ability to provide services to our beneficiaries within the community.

One example of an outpatient therapy service that is a significant impact to our beneficiaries is the ability to offer intravenous infusions on an outpatient basis. There is a growing need for this service throughout our community, due to a noted increase in patient volume of 22% between fiscal years 2013 and 2015. Not being able to provide this service would result in beneficiaries having to travel outside of their community to receive this treatment, or worse yet the inability of the beneficiary to receive the outpatient service altogether. I strongly encourage this committee to extend the enforcement delay on direct supervision requirements for outpatient therapeutic services provided in CAHs for calendar year 2015. I would also encourage a more permanent fix to provide a solution and support the adoption of a default standard of "general supervision" for these outpatient therapeutic services. Again, I strongly encourage the subcommittee to work to pass H.R. 2878 as well as legislation that would address this problem on a more permanent basis.

A second area of concern is the 96-hour physician certification requirement related to the Medicare condition of participation on the length of stay for critical access hospitals. The current Medicare condition of participation requires critical access hospitals to provide acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. In contrast, the Medicare condition of payment for critical access hospitals requires a physician to certify that a beneficiary may reasonably be expected to be discharged within 96 hours after admission to the critical access hospital. As a rural hospital administrator, I can say with certainty that the discrepancies between the conditions of participation and conditions of payment have caused confusion and challenges for critical access

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Holton Community Hospital
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1110 Columbine Drive, Holton, KS 66436 • 785-364-2116
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hospitals. This regulation also impedes the ability of the person who knows the needs of the patient best – the physician and other health care providers, and may unnecessarily cause patients to receive care away from their community. Accordingly, I urge Congress to pass the Critical Hospital Relief Act (H.R. 169), introduced by Representatives Adrian Smith, Lynn Jenkins, Todd Young, and David Loebsack. This legislation would remove the Medicare condition of participation that requires a physician to certify that a patient is reasonably expected to be transferred or released within 96 hours. The bill would leave in place the Medicare condition of payment requiring critical access hospitals to maintain an average annual length of stay of 96 hours or less.

On behalf of my organization, and similar rural organizations across the state of Kansas and our nation, it is critically important that our communities are able to access quality health care services. The increasing and unwarranted regulatory burdens that are being placed on health care providers place this access in jeopardy. I would not want to imagine what would happen to patients, similar to a patient just a few days ago in our Emergency Department, who sought treatment after moving heavy equipment at his rural home. He was rapidly identified as having a heart attack, provided stabilization, and transferred the nearest facility with a cath lab. He received successful intervention, and later discharged home. This positive outcome for our beneficiaries and our communities would not be possible without the ability to have access to quality care in a timely fashion. Therefore, steps should be taken to minimize the regulatory burdens that are placed on our rural health care providers and the outcome that affects our communities.

I am honored for the opportunity to submit testimony regarding the action that Congress can take to address rural healthcare disparities created by Medicare regulations. I would be happy to answer questions.

Chairman BRADY. Thank you.

Mr. Derksen, you are recognized for 5 minutes.

STATEMENT OF DANIEL DERKSEN, DIRECTOR, ARIZONA CENTER FOR RURAL HEALTH, TUCSON, ARIZONA

Dr. DERKSEN. Chairman Brady, Ranking Member McDermott, and committee members, I really do thank you for your service on this very important issue. But, especially, I want to thank you—thank you, thank you—for getting rid of that awful sustained growth rate formula, so we don't have to come back every year and do the doc fix.

I am particularly gratified as a family physician myself in the last 30 years to see a nurse and physician on this committee. I think it is very important when we inform policy that we have Members of Congress that understand what it is like to be in the trenches serving patients.

I want to hit on a couple of issues. I am a family physician. I work in an academic health center. I ran a faculty practice plan, the worst 2 years of my life—I call it the "thousand points of veto," with 550 faculty members and 450 resident physicians; everyone felt like we could do things a little differently than we were. I think it is particularly important as we look at how professions education is, how do we get a better return on our Federal investment? We are spending $15.5 billion on graduate medical education in this country. Thank you for that investment in higher education. But I think we could get a better return on that investment. I think we need to move from protecting the status quo and holding harmless. Let's hold accountable.

I think we can do better in the $10 billion we are spending in Medicare GME to diversify our investment portfolio to include, for example, teaching health centers, which you also renewed as part of the MACRA legislation to extend teaching health center funding for another 2 years. In comparison, we only spent $230 million over the last 5 years in teaching health centers, which is really to improve the health profession's workforce in rural areas.

Some States, including in New Mexico and Arizona in the Southwest, are experimenting with I think very innovative models in interprofessional teaching health centers, leveraging Medicaid graduate medical education to achieve better outcomes.

You have heard about some of the arcane rules that make it very difficult for rural hospitals and Critical Access Hospitals to maintain and keep their doors open and provide the services that are so important to rural hospitals. I think the two-midnight rule, the 96-hour rule really undermine a physician's judgment. You don't always know, having admitted hundreds of patients in both urban and rural hospitals myself in 30 years of practice, how long it is going to be for someone to be there. I think it is reasonable as a condition of participation to, on average, have 96 hours' admissions for Critical Access Hospital, but it is unreasonable and unfair to make it a condition of payment that if someone exceeds 96 hours in a Critical Access Hospitals that they won't get paid.

As I was getting on the plane in Phoenix, I got a series, a flurry of email messages from one of our rural hospitals, our Critical Access Hospitals, on U.S.-Mexico border. Cochise Regional serves

20,000 individuals in a county that—its land mass would contain both Delaware and Connecticut. It is a very large area. It is critical. They will close their doors on Friday because Medicare stopped payment to them.

The glacial appeals process will often put a rural hospital under because it takes so long to work through the appeal. We have seen over the last 5 years, 54 rural hospitals close according to the Sheps Center. There is another 283 that are on the verge of closure, at risk of closure, including hospitals in States that you all represent. Fourteen of you represent States that either have hospitals that are closing, especially in Texas, but also in other areas as well.

I think we need to basically streamline that appeal process. We need to make sure that those auditors, such as the RAC auditors, that are paid on a contingency fee, that there is a penalty when they make a mistake and that we don't put our rural hospitals at risk of closure by this glacial process.

The last thing I would say is there are some very good models you can draw on. You heard some last week from Mr. Miller in the MedPAC about how we might better invest our GME dollars. There is certainly some wonderful suggestions in the Institute of Medicine report about how we might do this. But I think there is also some interesting models happening at the State level, but we have to titrate these changes that we are requiring of rural hospitals on quality reporting. We have to make sure that when they report on quality and their payment is tied to it, that they are ready to do that. I think Arizona, for example, through its Medicaid program has a Critical Access Hospital pool and a rural pool that could be modified slightly to pay them on the basis of value and outcomes. I think these issues would really help us move forward in providing the access in our rural areas, create great jobs in those areas and continue that 24-hour-a-day, 7-day-a-week access to care that is so important in our rural communities. Thank you.

[The prepared statement of Mr. Derksen follows:]

THE UNIVERSITY OF ARIZONA
MEL & ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health

Daniel Derksen, M.D., Director
1203 N Martin Avenue
P.O. Box 245177
Tucson, AZ 85724-5177
Tel: (520) 626-5825
www.crh.arizona.edu

Statement of
Daniel Derksen, M.D.
Walter H. Pearce Endowed Chair and Director
Arizona Center for Rural Health
Professor & Chair of the Community, Environment & Policy Department
Mel and Enid Zuckerman College of Public Health
The University of Arizona

Before the
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Rural Health Care Disparities Created by Medicare Regulations & Payment
July 28, 2015 at 10:00 A.M. in 1100 Longworth House Office Building

Chairman Brady, Ranking Member McDermott, distinguished Committee members – my name is Dan Derksen. I am the director of the Center for Rural Health at the University of Arizona College of Public Health. I am honored to provide expert testimony on rural health and disparities created by Medicare regulations. I have over 30 years experience working as a family physician and faculty member at two public land grant universities.

Today I am not representing the University or any other entity. I draw on my three decades of experience - as a family physician practicing in underserved sites where most of my patients were on Medicare or Medicaid, or were uninsured; as a faculty member creating training programs and preparing health professions students to practice in rural communities; as director of an academic faculty practice plan; as a director working for a Governor to establish a state-based health insurance marketplace; and as at health policy fellow working for a U.S. Senator researching and drafting legislation to improve the supply and distribution of the health workforce to rural areas.

You have heard the rural health challenges: fewer health providers, poorer health outcomes, higher rates of poverty and uninsured. Medicare regulations, cuts and threats to Medicare payment – such as disproportionate share hospital (DSH) payment, graduate medical education (GME) payment and arcane regulatory burdens including the Two Midnight Rule, 96-hour Rule, and onerous and costly reporting and auditing requirements - do not improve health outcomes. These catalyze the closure of

THE UNIVERSITY OF ARIZONA
MEL & ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health

Daniel Derksen, M.D., Director
1295 N Martin Avenue
P.O. Box 245177
Tucson, AZ 85724-5177
Tel: (520) 626-5823
www.crh.arizona.edu

an alarming number of our nation's rural hospitals (54 since 2010)[1], and push many more to the brink of fiscal extermination (283 rural hospitals at risk of closure)[2]. To bring this message home to the Members of this Health Subcommittee, that translates to 10 Members representing states with rural hospital closures since 2010 (CA, GA, KS, NE, TN, TX, WI) and 14 Members from states with rural hospitals at risk of closure (CA, FL, GA, IL, KS, NE, TN, TX, WA, WI).[1,2]

Medicaid (+12.3 million[3]) and the Marketplace (+8.7 million receiving advance premium tax credits[4]) covered many more Americans in 2014-15, intensifying demand for health services especially in rural counties where 77% are federally designated primary care Health Professions Shortage Areas[5]. Expanded coverage has improved hospital fiscal margins over the last 18 months. To assure ready access to high quality, cost efficient health care, private physicians and health providers, Critical Access Hospitals, Rural Hospitals, Rural Health Clinics, Federally Qualified Health Centers, and health professions education and training programs play crucial roles.

The real challenge is to move beyond the comfortable "hold harmless" to the "hold accountable" approaches that yield a better return on our public investment, that measurably improve health outcomes, and use formulas that anyone can understand.

I will discuss innovative approaches and provide specific examples, of how some communities are improving access to high quality, cost efficient rural health care; moving the health professions training pipeline closer to areas of high need; creating jobs and spurring economic growth in rural communities; while assuring the health and wellness of rural populations.

(1) *Graduate Medical Education (GME) – Yielding a Better Return On Our Public Investment* - Our nation spends $15.5 billion per year[6], $10 billion by Medicare for direct and indirect

[1] Rural Hospital Closures: January 2010 – Present. Sheps Center for Health Services Research. Accessed 7/26/15 at:
[2] Topchik M: Vulnerability to Value 2015. iVantage Health Analytics. Accessed 7/26/15 at: http://info.ivantagehealth.com/rural-relevance-2015-study-request-0
[3] Medicaid & CHIP: April 2015 Enrollment Report June 23, 2015. Accessed 7/16/15 at: http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/april-2015-enrollment-report.pdf
[4] Marketplace Enrollees. Kaiser Family Foundation. Accessed 7/26/15 at: http://kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/
[5] WWAMI Rural Health Research Center. Accessed 7/26/15 at:
http://depts.washington.edu/uwrhrc/uploads/Rural_Primary_Care_PB_2009.pdf
[6] GME That Meets the Nation's Health Needs. Institute of Medicine. Accessed 7/26/15 at:
http://iom.nationalacademies.org/Reports/2014/Graduate-Medical-Education-That-Meets-the-Nations-Health-Needs.aspx

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Tucson, AZ 85724-5177
Tel: (520) 626-5823
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GME, and almost $4 billion in the 42 states using Medicaid funds[7] to support GME to train physicians in residencies after completing undergraduate education in medical allopathic and osteopathic schools. As more are covered, demand for health care increases, especially in rural areas. Rural training programs have demonstrated success training health professionals that practice in the high need primary care specialties in the areas they are most needed.

To complement the outstanding education in urban academic health centers, Teaching Health Centers (THCs) intend to move the primary care training pipeline closer to areas of need. THCs are now in: AL, AK, AZ, CA, CT, ID, IL, IA, KY, ME, MA, MI, MO, MT, NM, NY, NC, OK, PA, TX, WA, WV. Some are testing new THC models, to include nurse practitioners and other health providers in community-based teams to assure the nation's rural communities have the health workforce they need, such as in New Mexico, leveraging Medicaid GME to invest in the health professions training pipeline[8].

MedPAC testified recently that Medicare pays hospitals more than $3.5 billion above their empirically justified costs for indirect GME (IME) hospital payment[9]. I have worked in academic health centers for 30 years, and have researched and drafted federal and state legislative interventions. Based on those experiences, my suggestions are to:

a) Diversify Medicare and Medicaid GME investments to include Teaching Health Centers, to reform the structure and financing of primary care GME[10].
b) Invest Medicare current GME dollars more strategically – there are many approaches such as those suggested by MedPAC and the IOM[6,9].
c) Address the wide variation in Medicare GME payment between states[11]. Why should New York receive nine times more Medicare GME funding per capita than Texas (NY =

[7] Teaching Health Centers. Health Affairs Blog. Accessed 7/26/15 at: http://healthaffairs.org/blog/2014/10/17/teaching-health-centers-an-attainable-near-term-pathway-to-expand-graduate-medical-education/
[8] HB 310: Creation of Primary Care Residency Slots through FQHC THC Program. Accessed 7/22/15: http://www.nmlegis.gov/Sessions/14%20regular/bills/house/HB0310.PDF
[9] MedPAC Committee on Ways and Means testimony of 7/22/15 at: http://www.medpac.gov/documents/congressional-testimony/testimony-hospital-policy-issues-(ways-and-means).pdf?sfvrsn=0
[10] Proposal for reform of the structure and financing of primary care GME. Fam Med. 2013. Accessed 7/26/15 at: http://www.ncbi.nlm.nih.gov/pubmed/23463428
[11] Mullan F: Geography of GME. Accessed 7/26/15 at: http://content.healthaffairs.org/content/32/11/1914.abstract

THE UNIVERSITY OF ARIZONA
MEL & ENID ZUCKERMAN COLLEGE OF PUBLIC HEALTH
Center for Rural Health

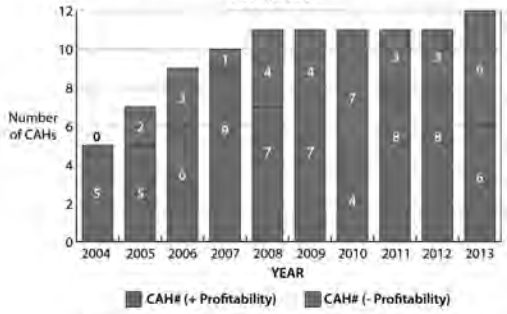
Daniel Derksen, M.D., Director
1295 N Martin Avenue
P.O. Box 245177
Tucson, AZ 85724-5177
Tel: (520) 626-5823
www.crh.arizona.edu

$103.63 per person, TX = 11.51)? Why should Connecticut receive $155,135 average Medicare payments, and others get half of that (TX $65,500; CA $87,121; GA $86,448)?

d) Let states innovate – use Medicaid GME, or a portion of current (e.g., IME) Medicare or new GME funding, to test and disseminate the interprofessional, community-based Teaching Health Centers needed to serve rural populations.

(2) Rural providers and hospitals struggle to maintain positive fiscal margins, and keep their doors open to serve their patients and communities. Small Medicare payment, regulatory or reporting changes can push them over the brink. Figure 1 illustrates 12 Arizona Critical Access Hospital fiscal margins – half are negative. Diminishing Disproportionate Share Hospital (DSH) payments, fanatical Recovery Audit Contractors (RAC) with fiscal incentives (contingency fees) to deny payment without balancing penalties to extinguish inappropriate and unjustified denials also contribute to the hostile environment that threatens rural hospital survival. The tiered, glacial RAC denial appeal process requires a tenacity and commitment that many rural hospitals cannot sustain.

Figure 1: Arizona CAHs' Profitablility Summary 2004-2013



Source – Arizona Dept. of Health Services: Hospital Cost Reports (2004-2013)

THE UNIVERSITY OF ARIZONA
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Center for Rural Health

Daniel Derksen, M.D., Director
1295 N Martin Avenue
P.O. Box 245177
Tucson, AZ 85724-5177
Tel: (520) 626-5823
www.crh.arizona.edu

(3) Ease the Medicare rural hospital and physician regulatory burdens:

a) Eliminate the 96 Hour Rule as a condition of payment for Critical Access Hospitals (CAHs). As a family physician that has admitted hundreds of patients over the years in urban and in rural areas, it can be very difficult to determine which patients will require longer hospitalizations. CAHs can satisfy conditions of participation requiring an annual average of 96 hours length of stay.

b) Modify the Two-Midnight Rule – this complicated rule has almost everyone unhappy, but especially Medicare patients, who may be forced to pay more for services that are ruled outpatient. A prudent path forward would be for Congress to extend the partial enforcement delay of the two-midnight policy until March 30, 2016.

c) Align quality and satisfaction reporting for Medicaid and Medicare for rural hospitals and physicians. Critical Access Hospitals, community health centers, rural health clinics and physician practices have limited personnel, and high turnover of "C-suite" personnel – Chief Executive Officer, Chief Nursing Officer, Chief Medical Officer, Chief Financial Officer – making it difficult for hospitals and clinics to report metrics required for payment such as those reported on Hospital Compare for larger hospitals, Medicare Beneficiary Quality Improvement Project (MBQIP), and patient satisfaction in HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems). Increasingly, rural hospital and physician payments are tied to quality reporting and value based outcomes. Rural hospitals, physicians and health providers need training and support to help them prepare for value based payment changes, such as those in the 815-page proposed rule released in July by the Centers for Medicare and Medicaid Services relating to the Physician Fee Schedule. An intermediate step to value based payment – creating voluntary quality pools, based on the model of the rural and critical access pool Medicaid payments in the Arizona Health Care Cost Containment System (AHCCCS).

The simplest gauge of quality is whether we meet health needs. We must leverage our public Medicare dollars to reinvent health professions education and meet our nation's health needs.

Chairman Brady, Ranking Member McDermott, distinguished Members of the Committee - thank you for the opportunity to provide expert testimony.

Chairman BRADY. Thank you, Dr. Derksen. I agree with you. We need a new path forward on graduate medical education. And I think we need to recognize the changes in indirect medical education, the number of procedures that are occurring, outpatient versus inpatient, making sure we are really getting dollars to those who are providing the education and training for our future doctors.

So, Mr. Joslin, I have a question for you in a second about increasing risks in positions and rural hospitals. But, Ms. Sorensen, Ms. Saia, and Mr. Derksen, Critical Access Hospitals easily meet their annual average 96-hour condition of participation. But asking local doctors to certificate the specific patient's needs won't require a 4-day stay or less is creating we think some real difficulty among our Critical Access Hospitals.

So can you—for the committee's insight—can you provide some examples of what services typically fall well under the 96-hour rule and examples of some services that typically are well over the 96-hour limit? Ms. Sorensen?

Ms. SORENSEN. Typically, we see a lot of the outpatient—excuse me, not outpatient, but surgical procedures that would be done in our facility by the qualified providers that we have, maybe a bowel resection, maybe something related to a surgical removal, gallbladder, some of those things that didn't take—the bowel resection, obviously, always follows typically a 5-day stay. So when we admit on that day, yet we are supposed to precertify for 96 hours. Yet we are capable of doing those, we go through the proper training and competencies and surveys to do those, but for us to send them 150 miles away to get that done and not being able to come back to us is a big impact. Otherwise, we, obviously, have an annual average—our annual average runs around 70 hours so we see a number of those things that fall underneath that—the pneumonias, the other types of just acute illness that come in.

The biggest issue becomes if you send in a culture, test the infection, and it comes back something you weren't anticipating; now we need to change the medication, and so we are switching from one antibiotic to another. And now we are up on 96 hours, so what are we going to do? Are we going to go into a swing bed for a short stay because if we go there for a short stay, that is also a red flag? So we create a lot more barriers by having those issues.

Chairman BRADY. Great examples.

Ms. Saia.

Ms. SAIA. I would just add on, pneumonia is a great example where if it is simple, treatable, and you get the right antibiotic on the right day, that is easily treated within a 5-day stay. But if you have to culture on the second day, sometimes that culture usually take 72 hours to get the results back. There you are at your 5-day window. If you need to wait and see if you need to change the antibiotics to make sure it responds appropriately, you are past the 5-day window. Just another example where usually pneumonia can be treated very easily upon admission. The physician could certify they could be treated and discharged within 5 days, but during those first, 2, 3, days, if they are not responding to treatment and you need to change treatment, then you are past that 5-day window.

Chairman BRADY. Makes sense.

Dr. Derksen.

Dr. DERKSEN. Thank you, Mr. Chairman.

I ran an academic Locum Tenens Program, where we provided practice relief in our rural hospitals and emergency departments across the Southwest. And one of the things we noticed is things, like pneumonia, congestive heart failure, routine urosepsis, people with urinary tract infections that spread to their bloodstream, acute stroke, acute trauma, many times these are things that we could either treat or treat and then move on to a higher level of service in that 3-day timeframe, but you don't always know. A person could come in with a simple, straightforward immunity-acquired pneumonia, and then, because they are dehydrated, they develop acute renal failure. And you may not have the lab results back quick enough to be able to know right at the time that they are going to take another day or two until they are ready to go back home. So those are some examples. Thank you.

Chairman BRADY. So the point isn't the average of 96 hours; it is the specificity on every case where the patient may have some different needs that are just evolving as you are treating them.

Auditing, from Ms. Sorensen and Ms. Saia, I have heard mixed feedback regarding how CMS is auditing around the 96-hour COP for Critical Access—can you describe your experience, if any, with the surveyor who has audited your hospital around the 96-hour rule?

Ms. SORENSEN. Chairman Brady, I don't believe we have had any experience with an audit on that as of yet.

Chairman BRADY. Well, I am sorry I asked that question for your organization.

Ms. Saia.

Ms. SAIA. I am sorry you asked that, too. We have not been audited with regards to the 96 hour. I did before, in preparing for the testimony, went back and looked through 10 years of our submissions of where did our annual average end up for that year in regards to the length of stay, and the max that ever our average was, was 4 days, around 72 hours, so we have not been audited.

Chairman BRADY. Oh, I am sure you will be on someone's list now.

Again, really sorry about that.

Chairman BRADY. Mr. Joslin, last week, the committee heard testimony from Mark Miller, the executive director of MedPAC. He testified that increasing residency positions for hospitals in rural areas doesn't necessarily translate into those residents staying in rural areas. My experience has been, in Texas and our district, has been the opposite. Your thoughts, other than increasing the number of slots, what would you recommend to us to do to incentivize physicians trained in rural areas to stay there and practice medicine because it is so critical for communities like ours and certainly those on the subcommittee.

Mr. JOSLIN. Yeah, absolutely, it is such a critical issue because underserved areas are so difficult to recruit physicians to in the first place. Obviously, the economics play a major role in that. And so you have to have other ways to get physicians there. I am not familiar with the testimony of the MedPAC individual.

Although, my experience has been different. My experience has been when you do provide training and additional training in those areas, a large percentage of those residents do stay. If you look at us, for example, over the last 40 years, we have trained 3,000 residents, and a 1,000 of them have stayed in the Valley. They don't just stay in Fresno; they stay in these outlying rural areas. We serve a 15,000 square mile radius, a large geographic area. And a lot of that is underserved and rural, and that is where the physicians are staying. Over the last 4 years alone, we have had 120 of those residents stay and practice in these rural areas.

So I would argue that training does pay if it ends relative to the physicians staying in these areas. At least our statistics show that at least 30 percent of the physicians that we train do stay in these areas. So I think that is critical. I do think there are other things and creative ideas that are being suggested and how we can provide specific training in these rural areas that also supplements the GME, slots that are currently available. It is not just funding additional slots, but certainly looking at the way those slots are allocated within States, which is a huge problem for us. In California, for example, if you look at California, relative to the Central Valley, it is very skewed because the Central Valley is the poorest area. As I mentioned earlier, it is about the fifth poorest area in the country, but when you factor in Los Angeles and San Francisco, the numbers are very skewed. And so you have to also then start looking within States and looking at underserved areas within States. And our area is a perfect example. In central California, we have 48 primary care physicians per 100,000 residents. In San Francisco Bay area, they have 85, and so, obviously, there is not the same dire need in the San Francisco Bay area, and I am not minimizing their issues by any means. I am simply saying that when you look at how you are provided slots, I mean, there are two issues associated with that. Certainly there is the number of slots you provide, but certainly just as important is how you allocate those slots. And really the whole intent of this program is to help get physicians in underserved areas. There has to be a key component of that. Our slots have been captive since 1997, and that issue needs to be respectfully revisited so that these underserved areas like ours can do something because if we don't, they are going to continue to do what they are doing today, which is just showing up in the emergency room.

Chairman BRADY. Thank you, Mr. Joslin.

And, Dr. McDermott, you are recognized.

Mr. MCDERMOTT. Ms. Saia, you testified before the—you reported in a Topeka news report saying, quote: "If Medicaid would expand, it would be over a $300,000 impact of Holton Hospital, where some years that is the difference of us being a profitable hospital or not." Would you tell us how expanding Medicaid would make it better in your State?

Ms. SAIA. How—could you ask the question again?

Mr. MCDERMOTT. What percentage of your patients come in with no insurance, no anything? I mean, what I am trying to get at, Governors who made a decision not to do Medicaid expansion leave you hanging out to dry in the rural areas, with people coming

in who are sick and you can't turn them away. Tell me about the problem of your hospital.

Ms. SAIA. So expanding Medicaid in different pockets and different service areas, the emergency department is where our largest volume of uncompensated care is given, and that percentage is right around 20 percent, which is smaller than a lot of other facilities, but that 20 percent is directly written off as uncompensated care.

Mr. MCDERMOTT. How much money is 20 percent?

Ms. SAIA. Twenty percent of our emergency department volumes? I would have to submit written testimony back to you. If I could get back to you——

Mr. MCDERMOTT. I would appreciate that.

Ms. Sorensen, you said before the Nebraska legislature a reduction in uncompensated care and cost shifting, better work health, and fewer bankruptcies, less ACA penalties for business owners, a shift of some of the States direct cost to Medicaid would generate billions of dollars in Federal money. Tell me what does not being in Medicaid in Nebraska does for you?

Ms. SORENSEN. For us, it is really the economic impact that we have. So in our small rural community, we are 70 percent Medicare and what percentage of that then are also Medicaid, even just in the impact of we recently had our local nursing home close within our community, which was about 70 percent Medicaid as well as. So when we have that high level of care, that high continuum of care needed within that age and that population, that is the impact that we see, so now those aren't even in our community.

We don't have a real high percentage of Medicaid in our community. We run about 10 percent Medicaid, 8 percent self-pay in there, but really it just becomes more, as he mentioned, showing up and the access to the care. So now we are not getting in and doing the preventative screening. We are not doing the wellness pieces. We are just showing up in the ER for nonemergent cases, where the highest cost of care is given.

Mr. MCDERMOTT. When you have a stroke patient in your area, do you have a lab to test whether they should be given an infusion of medication to dissolve the clot?

Ms. SORENSEN. We do laboratory testing and CT scan at the point of arrival. Of course, with our distance, we are typically arranging for that transfer as soon as possible. And then, in Nebraska, we are utilizing some of the stroke cares that they are doing through the University of Nebraska Medical Center and pushing into all of our facilities on the most timely amount of care. And so we do stock the medications, but it also depends on we have to make sure they are stable before they go on that lengthy of a transfer.

Mr. MCDERMOTT. And do you use helicopters, or do you use just ambulances?

Ms. SORENSEN. Both. It depends. We have seen more air transfers out this year. It is as much as it was last year, already at this point halfway through the year. Some of that has been due to acuity. Some of that has also been due to time issues. So but, yeah, we have about 65 transfers that go out a year. And last year we

only had about 14 that went by air, and we are already at 14 so far this year.

Mr. MCDERMOTT. And if I understood your answer to Mr. Brady's question, neither of you have been audited so you are not exceeding or you have not come up on the radar screen at Medicare headquarters overextending your 96 hours. Is that right? Is that what you are telling me?

Ms. SORENSEN. Yes. I would say we have not been audited specifically for the 96-hour per stay. Of course, for all of our fiscal years, as Ms. Saia mentioned too, our average annual is well under the 96. So I don't think that would probably be something——

Mr. MCDERMOTT. Why is it a problem? Everybody says it is a big problem; we have to got to get rid of this 96-hour rule. But you never—you don't exceed it in your average, and so I am trying to understand, give me some examples of patients, you know, where it became a problem.

Ms. SORENSEN. Absolutely. The biggest issue is going to be, of course, the annual average falls in okay, but if we had a patient that had a surgical procedure——

Mr. MCDSERMOTT. Surgical procedure done there at your hospital?

Ms. SORENSEN. Yes, like a bowel resection or something, so they will be admitted into that acute status, but we already know ahead of time, they will probably be there for 5 days, just to get things back up and going and medically stable and everything, get them back to eating normal. And so with the per-stay condition of payment, that has been said to be enforced, that is where if we are certifying or precertifying they are going to be there less than 96 hours but really we anticipate them to be longer, we are not going to get paid for that stay.

The same thing happens—and maybe Ms. Saia wants to comment to that—in a pneumonia case, where we will admit on day one, doesn't seem to be responding to it, get the culture, something comes back. It comes back unexpected and we need to change medication. So now, even if we did precertify we reasonably expect them to be there less than 96 hours, now we are already at 90 hours; we need to change the medications. Are we running that risk? We are not even going to get paid for that entire episode.

Mr. MCDERMOTT. Mr. Chairman, I realize you have given me a little extra time here. I would like to submit the CMS rules on the 96-hour rule for the record. The rule explains that CHAs still get paid after 96 hours if the patient still needs care. Nobody is denied care. Nobody is denying payment apparently. So I would like to submit that for the record.

Chairman BRADY. Without objection.

[The information follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

January 30, 2014

Hospital Inpatient Admission Order and Certification

As a condition of payment for hospital inpatient services under Medicare Part A, section 1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis. The order to admit as an inpatient ("practitioner order") is a critical element of the physician certification, and is therefore also required for hospital inpatient coverage and payment under Part A. The physician certification, which includes the practitioner order, is considered along with other documentation in the medical record as evidence that hospital inpatient service(s) were reasonable and necessary. When a physician signs the certification, they are certifying that inpatient hospital services were reasonable and necessary.

The following guidance applies to all inpatient hospital and critical access hospital (CAH) services unless otherwise specified. For the remainder of this guidance, when we refer to hospitals, we are also referring to CAHs. The complete requirements for the physician certification are found in 42 CFR Part 424 subpart B and 42 CFR 412.3. An electronic version of the CFR is available online at: http://www.ecfr.gov/cgi-bin/text-idx?sid=0ccf28130d181e0b9118119c2b4d40ed&c=ecfr&tpl=/ecfrbrowse/Title42/42tab_02.tpl.

A. Physician Certification. For physician certification of inpatient services of hospitals other than inpatient psychiatric facilities:

1. **Content:** The physician certification includes the following information:
   a. Authentication of the practitioner order: The physician certifies that the inpatient services were ordered in accordance with the Medicare regulations governing the order. This includes certification that hospital inpatient services are reasonable and necessary and in the case of services not specified as inpatient-only under 42 CFR 419.22(n), that they are appropriately provided as inpatient services in accordance with the 2-midnight benchmark. The requirement to authenticate the practitioner order may be met by the signature or countersignature of the inpatient admission order by the certifying physician.

   b. Reason for inpatient services: The physician certifies the reasons for either— (i) Hospitalization of the patient for inpatient medical treatment or medically required inpatient diagnostic study; or (ii) Special or unusual services for outlier cases under the applicable prospective payment system for inpatient services. For example, documentation of an admitting diagnosis could fulfill this part of the certification requirement.

   c. The estimated (or actual) time the beneficiary requires or required in the hospital: The physician certifies the estimated time in the hospital the beneficiary requires (if the certification is completed prior to discharge) or the actual time in the hospital (if the certification is completed at discharge). Estimated or actual length of stay is most commonly reflected in the progress notes where the practitioner discusses the assessment

and plan. For the purposes of meeting the requirement for certification, expected or actual length of stay may be documented in the order or a separate certification or recertification form, but it is also acceptable if discussed in the progress notes assessment and plan or as part of routine discharge planning.

If the reason an inpatient is still in the hospital is that they are waiting for availability of a skilled nursing facility (SNF) bed, 42 CFR 424.13(c) and 424.14(e) provide that a beneficiary who is already appropriately an inpatient can be kept in the hospital as an inpatient if the only reason they remain in the hospital is they are waiting for a post-acute SNF bed. The physician may certify the need for continued inpatient admission on this basis.

d. The plans for posthospital care, if appropriate, and as provided in 42 CFR 424.13.

e. For inpatient CAH services only, the physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

Time as an outpatient at the CAH does not count towards the 96 hours requirement. The clock for the 96 hours only begins once the individual is admitted to the CAH as an inpatient. Time in a CAH swing-bed also does not count towards the 96 hour inpatient limit.

If a physician certifies in good faith that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH and something unforeseen occurs that causes the individual to stay longer at the CAH, there would not be a problem with regards to the CAH designation as long as that individual's stay does not cause the CAH to exceed its 96-hour annual average condition of participation requirement. However, if a physician cannot in good faith certify that an individual may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH, the CAH will not receive Medicare reimbursement for any portion of that individual's inpatient stay.

f. Inpatient Rehabilitation Facilities (IRFs): The documentation that IRFs are already required to complete to meet the IRF coverage requirements (such as the preadmission screening (including the physician review and concurrence), the post-admission physician evaluation, and the required admission orders) may be used to satisfy the certification and recertification statement requirements.

2. **Timing:** Certification begins with the order for inpatient admission. The certification must be completed, signed, dated and documented in the medical record prior to discharge, except for outlier cases which must be certified and recertified as provided in 42 CFR 424.13. Under extenuating circumstances, delayed initial certification or recertification of an outlier case may be acceptable as long as it does not extend past discharge. With regard to the time of discharge, a Medicare beneficiary is considered a patient of the hospital until the effectuation of activities typically specified by the physician as having to occur prior to discharge (e.g., "discharge after supper" or "discharge after voids"). So discharge itself can but does not always coincide exactly with the time that the discharge order is written, rather it occurs when the physician's order for discharge is effectuated.

3. **Authorization to sign the certification:** The certification or recertification may be signed only by one of the following:

(1) A physician who is a doctor of medicine or osteopathy.
(2) A dentist in the circumstances specified in 42 CFR 424.13(d).
(3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under state law.

Certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff (or by the dentist as provided in 42 CFR 424.11). Medicare considers only the following physicians, podiatrists or dentists to have sufficient knowledge of the case to serve as the certifying physician: the admitting physician of record ("attending") or a physician on call for him or her; a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her; a dentist functioning as the admitting physician of record or as the surgeon responsible for a major dental procedure; and, in the specific case of a non-physician non-dentist admitting practitioner who is licensed by the state and has been granted privileges by the facility, a physician member of the hospital staff (such as a physician member of the utilization review committee) who has reviewed the case and who also enters into the record a complete certification statement that specifically contains all of the content elements discussed above. The admitting physician of record may be an emergency department physician or hospitalist. Medicare does not require the certifying physician to have inpatient admission privileges at the hospital.

4. **Format:** As specified in 42 CFR 424.11, no specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided for delayed certifications, there must be a separate signed statement for each certification or recertification. If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that hospital inpatient services are or continue to be medically necessary.

B. Inpatient Order: A Medicare beneficiary is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner. As we stated in the CY 2014 IPPS final rule, if the order is not properly documented in the medical record, the hospital should not submit a claim for Part A payment (78 FR 50941). Meeting the 2 midnight benchmark does not, in itself, render a beneficiary an inpatient or serve to qualify them for payment under Part A. Rather, as provided in our regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if they are formally admitted as such pursuant to an order for inpatient admission by a physician or other required practitioner.

1. **Content:** The practitioner order contains the instruction that the beneficiary should be formally admitted for hospital inpatient care. The order must specify admission for inpatient services. Inpatient rehabilitation facilities (IRFs) also must adhere to the admission requirements specified in 42 CFR 412.622, and the 2-midnight benchmark does not apply in IRFs.

2. **Qualifications of the ordering/admitting practitioner:** The order must be furnished by a physician or other practitioner ("ordering practitioner") who is: (a) licensed by the state to admit inpatients to hospitals, (b) granted privileges by the hospital to admit inpatients to that specific facility, and (c) knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission. The ordering practitioner makes the determination of medical necessity for inpatient care and renders the admission decision. The ordering practitioner is not required to write the order but must sign the order reflecting that he or she has made the decision to admit the patient for inpatient services.

   The ordering practitioner may be, but is not required to be, the physician who signs the certification. Please see section (B)(3) for a discussion of the requirements to be knowledgeable about the patient's hospital course. See section (A)(3) for the list of physicians authorized to certify a given case.

   The admission decision (order) may not be delegated to another individual who is not authorized by the state to admit patients, or has not been granted admitting privileges by the hospital's medical staff (42 CFR 412.3(b)). However, a medical resident, a physician assistant, nurse practitioner, or other non-physician practitioner may act as a proxy for the ordering practitioner provided they are authorized under state law to admit patients and the requirements outlined below are met.

   a. **Residents and non-physician practitioners authorized to make initial admission decisions-** Certain non-physician practitioners and residents working within their residency program are authorized by the state in which the hospital is located to admit inpatients, and are allowed by hospital by-laws or policies to do the same. The ordering practitioner may allow these individuals to write inpatient admission orders on his or her behalf, if the ordering practitioner approves and accepts responsibility for the admission decision by counter-signing the order prior to discharge. (Please see (A)(2) for guidance regarding the definition of discharge time and (B)(3) for more guidance regarding knowledge of a patient's hospital course). In countersigning the order, the ordering practitioner approves and accepts responsibility for the admission decision. This process may also be used for physicians (such as emergency department physicians) who do not have admitting privileges but are authorized by the hospital to issue temporary or "bridge" inpatient admission orders.

The countersigned order satisfies the order part of the physician certification, as long as the ordering practitioner also meets the requirements for a certifying physician in section (A)(3).

b. **Verbal orders-** At some hospitals, practitioners who lack the authority to admit inpatients under state laws and hospital by-laws (such as a registered nurse) may nonetheless enter the inpatient admission order as a verbal order. In these cases, the ordering practitioner directly communicates the inpatient admission order to staff as a verbal (not standing) order, and the ordering practitioner need not separately record the order to admit. Following discussion with and at the direction of the ordering practitioner, a verbal order for inpatient admission may be documented by an individual who is not qualified to admit patients in his or her own right, as long as that documentation (transcription) of the order for inpatient admission is in accordance with state law including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. In this case, the staff receiving the verbal order must document the verbal order in the medical record at the time it is received. The order must identify the qualified "admitting practitioner", and must be authenticated (countersigned) by the ordering practitioner promptly and prior to discharge. (Please see (A)(2) for guidance regarding the definition of discharge time).

   A transcribed and authenticated verbal order for inpatient admission satisfies the order part of the physician certification as long as the ordering practitioner also meets the requirements for a certifying physician in section (A)(3).

   Example: "Admit to inpatient per Dr. Smith" would be considered an acceptable method of identifying the ordering practitioner and would meet the verbal order requirement if the verbal order (1) is appropriately documented in the medical record by the individual receiving the verbal order when the order is received; and (2) is authenticated (countersigned) by Dr. Smith promptly, prior to discharge. If Dr. Smith meets the qualifications for a certifying physician, then the authentication (countersignature) of this order by Dr. Smith also meets the requirement for the order component of the certification.

c. **Standing orders and protocols-** The inpatient admission order cannot be a standing order. While Medicare's rules do not prohibit use of a protocol or algorithm that is part of a protocol, only the ordering practitioner, or a resident or other practitioner acting on his or her behalf under section (B)(2)(a) can make and take responsibility for the inpatient admission decision.

d. **Commencement of inpatient status**- Inpatient status begins at the time of formal admission by the hospital pursuant to the physician order, including an initial order (under (B)(2)(a)) or a verbal order (under (B)(2)(b)) that is countersigned timely, by authorized individuals, as required in this section. If the physician or other practitioner responsible for countersigning an initial order or verbal order does not agree that inpatient admission was appropriate or valid (including an unauthorized verbal order), he or she should not countersign the order and the beneficiary is not considered to be an inpatient. The hospital stay may be billed to Part B as a hospital outpatient encounter.

3. **Knowledge of the patient's hospital course:** Medicare considers only the following practitioners to have sufficient knowledge about the beneficiary's hospital course, medical plan of care, and current condition to serve as the ordering practitioner: the admitting physician of record

("attending") or a physician on call for him or her, primary or covering hospitalists caring for the patient in the hospital, the beneficiary's primary care practitioner or a physician on call for the primary care practitioner, a surgeon responsible for a major surgical procedure on the beneficiary or a surgeon on call for him or her, emergency or clinic practitioners caring for the beneficiary at the point of inpatient admission, and other practitioners qualified to admit inpatients and actively treating the beneficiary at the point of the inpatient admission decision. Although a utilization review committee physician may sign the certification on behalf of a non-physician admitting practitioner, a practitioner functioning in that role does not have direct responsibility for the care of the patient and is therefore not considered to be sufficiently knowledgeable to order the inpatient admission. The order must be written by one of the above practitioners directly involved with the care of the beneficiary, and a utilization committee physician may only write the order to admit if he or she is not acting in a utilization review capacity and fulfills one of the direct patient care roles, such as the attending physician. Utilization review may not be conducted by any individual who was professionally involved in the care of the patient whose case is being reviewed (42 CFR 482.30(d)(3)).

4. **Timing:** The order must be furnished at or before the time of the inpatient admission. The order can be written in advance of the formal admission (e.g., for a pre-scheduled surgery), but the inpatient admission does not occur until formal admission by the hospital. Conversely, in the unusual case in which a patient is formally admitted as an inpatient prior to an order to admit and there is no documented verbal order, the inpatient stay should not be considered to commence until the inpatient admission order is documented. Medicare does not permit retroactive orders. Authentication of the order is required prior to discharge and may be performed and documented as part of the physician certification.

5. **Specificity of the Order**: The regulations at 42 CFR 412.3 require that, as a condition of payment, an order for inpatient admission must be present in the medical record. The preamble of the FY 2014 IPPS Final Rule at 78 FR 50942 specifies that, "the order must specify the admitting practitioner's recommendation to admit 'to inpatient,' 'as an inpatient,' 'for inpatient services,' or similar language specifying his or her recommendation for inpatient care." While we are not requiring specific language to be used on the inpatient admission order, we believe that it is the interest of the hospital that the admitting practitioner use language that clearly expresses intent to admit the patient as inpatient that will be commonly understood by any individual that could potentially review documentation of the inpatient stay. We do not recommend using language that may have specific meaning individuals that work in the hospital (e.g. "admit to 7W") that will not be commonly understood by others.

   Treatment of such admission orders as properly inpatient is consistent with CMS' historical interpretation of inpatient admission orders and hospitals' historical standards of practice. However, if the usage of the order to specify inpatient or outpatient status is ambiguous, the hospital is encouraged to obtain and document clarification from the physician before initial Medicare billing (ideally before the beneficiary is discharged). Under this policy, CMS will continue to treat orders that specify a typically outpatient or other limited service (e.g., admit "to ER," "to Observation," "to Recovery," "to Outpatient Surgery," "to Day Surgery," or "to Short Stay Surgery") as defining a non-inpatient service, and such orders will not be treated as meeting the inpatient admission requirements.

The admission order is evidence of the decision by the physician (or other practitioner who can order inpatient services) to admit the beneficiary to inpatient status. In extremely rare circumstances, the order to admit may be missing or defective (that is, illegible, or incomplete, for example "inpatient" is not specified), yet the intent, decision, and recommendation of the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient can clearly be derived from the medical record. In these extremely rare situations, we have provided contractors with discretion to determine that this information constructively satisfies the requirement that the hospital inpatient admission order be present in the medical record. However, in order for the documentation to provide acceptable evidence to support the hospital inpatient admission, thus satisfying the requirement for the physician order, there can be no uncertainty regarding the intent, decision, and recommendation by the physician (or other practitioner who can order inpatient services) to admit the beneficiary as an inpatient, and no reasonable possibility that the care could have been adequately provided in an outpatient setting.

This narrow and limited alternative method of satisfying the requirement for documentation of the inpatient admission order in the medical record should be extremely rare, and may only be applied at the discretion of the medical review contractor. Even in those circumstances, all requirements for the other components of the physician certification must be met.

Chairman BRADY. And, clearly, we appreciate the witnesses being here today. Usually witnesses come because there is a problem, especially when it deals with treatments for patients in real life. Today's hearing is about drawing some of those insights out, see how we can address them.

Mr. Johnson, you are recognized.

Mr. JOHNSON. Thank you, Mr. Chairman.

Thank you all for testifying today, and I appreciate you for being here. My district in Texas is right outside of Dallas and fairly suburban, but no mistake, I still understand the importance of our rural and critical access hospitals. You drive just one or two counties away, and you are going to find rural hospitals, and rural hospitals cover about 85 percent of the Texas geography.

Medicare has long had the so-called 96-hour rule, and some of you covered that in their testimony, but for years, CMS has enforced that rule based on the average patient's stay. But now CMS has changed their enforcement to require doctors to certify for each and every patient that they do not expect the patient to be there more than 96 hours.

Changing from an average of 96 to requiring certification for each patient doesn't at first sound like a big deal, but as you know and we have been talking about it, the implications are significant.

Ms. Sorensen and Ms. Saia, could you discuss how this change to the 96-hour rule has impacted your hospitals, both from a financial and operational standpoint? And could you also address in what circumstances a patient might have to be at the hospital for more than 96 hours? And what happens if a patient is admitted for more than 96 hours? One at a time go ahead.

Ms. Sorensen.

Ms. SORENSEN. I would just comment to the example I gave a little bit earlier relative to pneumonia and a change in medications. A surgical procedure where there was a bowel resection or organ removal, biopsy excision, those types of things that may alter that. Also just the usual if treatment doesn't go as planned and a medical care plan needs to be adjusted or modified to improve patient status.

Mr. JOHNSON. Go ahead, Ms. Saia.

Ms. SAIA. As previously mentioned, the regulation is confusing and conflicting from the condition of participation. So to be able to abide by the regulation as it stands, the physician must certify that they do not believe the patient is going to stay longer than 96 hours. So if—and my understanding and I may be corrected—but my understanding is that the payment would not occur after 96 hours, and therefore, we would need to ship the person from our facility to a larger facility that could care for that patient, that is taking—would impact the patient as well as where they are getting their care. So it would move their community—their loved ones to another facility if we are unable—are those buzzings me, I am sorry—if we are not able to care for that patient past that 96 hours, and you just never know. You don't have a crystal ball that tells you the answers as a provider upon admission what is going to change during that course of stay. So, with the 96-hour, the understanding and trying to enforce that and abide by that, the un-

derstanding is that they need to be transferred if their care needs longer than 96 hours.

Mr. JOHNSON. Were you all geared up to do that? I mean, you don't have an ambulance on standby just to take somebody to another hospital, do you?

Ms. SAIA. No.

Mr. JOHNSON. I didn't think so. And I think that is crazy to even think about, don't you? But do you get paid if they are over 96 hours?

Ms. SAIA. Do we get paid? Well, so far, the enforcement of that has been delayed, so we are not upheld to that current standard right now.

Mr. JOHNSON. Okay.

Ms. SAIA. We are just upheld to the condition to participation, not of payment.

Mr. JOHNSON. But they are pushing you to do that.

Ms. SAIA. Pushing and we with like you to push for the delay to continue and look at a more permanent fix. If we are not able to delay that, could we at least look at a permanent fix for that?

Mr. JOHNSON. Thank you very much.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Thompson, you are recognized.

Mr. THOMPSON. Thank you, Mr. Chairman.

And thank you to all the witnesses for coming. It has been good testimony. And I know you guys—I represented a rural area for most of the time I spent both in the State legislature and in Congress, so I know some of the challenges you have. And my wife is a healthcare provider in a rural hospital in my current district. And so I know very firsthand how challenging it can be. So thank you for helping us understand the problems and trying to figure out some solutions to the challenges that you face.

I am a big supporter of telemedicine and telemonitoring. I have had a number of pieces of legislation that has helped advance this. Mrs. Black and I have legislation in this Congress to help move that forward again. And I think it is a way we can address a lot of the problems that we face. So I would like to know how your hospitals are using—if they are using, and if so, how they are using both telehealth and remote patient monitoring?

Start with Mr. Joslin. You don't have to do a thesis.

Mr. JOSLIN. Okay, thank you. We are a safety net hospital, and we work with the rural hospitals closely. In fact, we receive about 600 transfers a month from outlying hospitals. However, we do use telemedicine quite a bit as well. We do it through the University of California, San Francisco, and with their specialists as well. But we have been using telemedicine for the last several years as a key component of the care that we are providing to help rural hospitals in outlying areas and physicians and clinics as well, to extend that to as many providers as possible. Because with what is going on in health care, the need for population health, how we look at redesigning the system, it is not just hospital to hospital, hospitals to physicians, but there are a lot of other types of providers, and telemedicine is a critical component of that piece as well.

Ms. SORENSEN. I would agree we are a big proponent of telehealth. We use tele-emergency, so we have board-certified emergency docs in our emergency room at the push of a button 24/7. We also have remote pharmacists that oversee 100 percent of our inpatient medications. Teleradiologists, as well as just the one-on-one patient visits, many of them are used for oncology with an occasional orthopaedic followup. Psychology of course.

The biggest barrier that we have in telehealth is getting the physicians themselves into a scheduling routine and access to the electronic devices so that they either can do it right from their desk or an examine room in their clinic. And then, of course, reimbursement issues that come into the challenge as well. They are often not willing to see the patient via telehealth because of the reimbursement and payment issues. So, therefore, our patients drive 2½ hours for that 10-minute visit that could have been done via telehealth.

Ms. SAIA. We are currently not using telehealth services, but supportive of that. We are currently looking at meeting the needs of our community in regards to mental health and exploring opportunities with a couple of different companies for telesite coverage.

Mr. THOMPSON. So you see it as something you can use or maybe should be using as something that can bring some relief.

Ms. SAIA. Yes.

Dr. DERKSEN. In Arizona, we were able to get legislation through for payment parity, so that insurers would be paying for telehealth services. We use it for teleradiology and places that can't afford to——

Mr. THOMPSON. The non face-to-face reimbursement.

Dr. DERKSEN. Exactly. So it has been very important, but it is also important to strike that balance between making those services available in rural communities, but making sure that, through licensing, credentialing, and privileging, that we assure the high quality of services that are available onsite. We don't have these kind of folks coming in from other places that undermine the fiscal viability of a place because someone else is kind of taking those services out of that community.

Mr. THOMPSON. A couple of you kind of alluded to some things, but are there any things specifically that would help you do more or better telehealth? Are there any roadblocks that Medicare reimbursements provide, or is there anything that Congress can do to help you better perform telehealth services?

Ms. SORENSEN. I would like to be able to provide written testimony with some more information because I need to look into that. But I know that just at a conference that I attended last week looking at that face-to-face reimbursement rate and what can actually be billed via that, there is a lot more opportunities available via telehealth, but right now we need to get that face-to-face reimbursement rate equal in telehealth.

Ms. SAIA. If possible, I would like to provide some additional testimony as well. We have looked at the tele-emergency coverage, and just the cost upfront I am told the cost of the salary of one FTE of a nurse. That is a little bit—when I was originally told that, that is probably less than what our current salary makes—it was closer to around $80,000. And just being able to come up

with that, making sure that we have got the adequate room in our emergency department is also a concern as well, so I would provide more written testimony on that.

Mr. THOMPSON. Thank you. I would invite to you get that written testimony, and I would be very interested in seeing it.

I don't know if the committee wants it, Mr, Chairman, but I sure would like to get it in my office.

Mr. THOMPSON. Thank you very much.

Chairman BRADY. Mr. Smith, you are recognized.

Mr. SMITH. Thank you, Mr. Chairman.

And certainly thank you to our panelists here today, our witnesses. I most admire your abilities and willingness to be on the frontlines of health care that are, I am sure, difficult. I don't pretend to think that the answers are here in Congress or even that there would be a bunch of answers in just increasing funding for some broken mechanisms in health care. I think that these arbitrary regulations that have come about, whether it is the 96-hour rule, whether it is the physician supervision, to keep those in place and just expand Medicaid, as some would suggest a solution would entail, I think we owe our providers a better policy than that out of Washington, D.C., that really entrusts our providers.

And, certainly, Shannon, thank you for being here, for traveling from very rural Nebraska to share your expertise, your insight. We know that Brown County Hospital is the only hospital in the county, hence the name. But the county has a land mass larger than the entire State of Rhode Island, and it happens to be next door to Cherry County, that is larger than the State of Connecticut, and it, too, only has one hospital.

So just to try to identify what the issues are here, we know the Critical Access Hospital designation I think is an effective component of our policy. But we ought not assume that every Critical Access Hospital has the same level of care or the same skills that are within that facility or the same community profile. And we need some flexibility.

That is why I have introduced the 96-hour rule, as well as the physician supervision bill that would push back there. These are arbitrary. I have a hard time even figuring out how they came about or why they came about. That story has not been told. But I do know that the 96-hour bill is a very bipartisan solution, with some 70 cosponsors, very bipartisan like I said. And these concerns are across America and I would say even in more urban areas too. Just the impact seems to be felt more at the rural level.

Now, there were some questions about audits. I mean, certainly I assume you have been audited but just not for 96-hour, right, I see strong nods in agreement, yes. So the RAC auditors, that was mentioned as well; that needs to be addressed. I am glad that telemedicine was brought up. I think that telehealth probably even adds to the need to address this 96-hour rule that is arbitrarily out there.

Do you want to elaborate a little bit on the audits that do take place, Ms. Sorensen or Ms. Saia.

Ms. SORENSEN. Absolutely. We have had audits for claims, overall episodes of care, what would be considered RAC. Our RAC activity has not been real high. But we definitely have had audits.

And these are very laborious. They are intensive in terms of submitting a number of additional supporting documentation and often for claims that we feel were unnecessarily audited or reviewed to look at in more detail. In all of them—and we have even gone to the level of having to appeal at the administrative law judge level. And the times that we have done that, we have been successful in appealing those but have not gone without much effort, time, and resources that has been needed to do that.

Mr. SMITH. Ms. Saia.

Ms. SAIA. We have been involved with a variety of different audits, the compensated care issue you mentioned previously. But our RAC audits have not, we have not had a lot of activity. There have been a very few small claims. But the time involved with reviewing those, making sure that claims were correctly submitted is very time-consuming. We have not been successful in two of them, in overturning the audit results. But, again, the activity has not been extremely high in regards to that.

Mr. SMITH. Okay. Thank you. And I do want to certainly emphasize the diversity of Critical Access Hospitals. As Ms. Sorensen said, there is one doctor for the entire hospital, the entire community, the county. Now, some Critical Access Hospitals would have 10, 15 docs, maybe, offering a different level of services. So 96 hours of care could mean different things in different communities. And I would hope that we can get our policies to reflect that.

Thank you, again, to our witnesses.

Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Thank you.

Mr. Davis, you are recognized.

Mr. DAVIS. Thank you very much, Mr. Chairman.

And I want to thank all of our witnesses.

You know, I was thinking, I grew up in rural America. Although I represent a large urban population, I have always had a great deal of affinity and, hopefully, some understanding of rural America's needs as it relates to health care. In my family, we often discuss the fact that we believe that my mother may have died prematurely because she had to travel more than 150 miles to get to a regional medical center where she could get dialysis treatment.

I am a big fan of regional medical centers like the ones, Mr. Joslin, that you come from and represent. But I also recognize that in training, we need to train the best physicians that we possibly can, not only in principles and concepts of medicine, but also there has to be enough opportunity for the individuals to experience disease entities enough times to, I mean, I always like physicians personally that I feel have seen a lot of patients like me and that, in the process of doing so, probably has a better understanding of whatever it is that I am there for.

In terms of finding a solution to obviously a very difficult problem, I mean, we look at reimbursement, and I think that reimbursement rates that are different based upon the complexity of small numbers of people that an entity might be able to see is something to consider. Obviously, telemedicine, as it continues to advance, and other types of incentives, how do you feel that these incentives can be tweaked enough or couched enough to really make a serious impact on the ability to recruit physicians and

other medical personnel for the rural areas that are having the difficulties we are discussing?

Mr. Joslin, perhaps we could start with you.

Mr. JOSLIN. It is a great question. I think there is two parts to that question. There is the question of how you tweak the system, but I think you have to start out with the fundamental realization that the system is flawed because the system is just not—it doesn't produce enough. And we touched on it earlier. We touched on the number of slots, and we touched on how these slots are allocated. And then trying to provide some type of incentive for physicians to want to go and train in these areas, whether it is financial incentive for educational purposes or however you structure something, but the shear magnitude of the issue is just the lack of enough slots in these underserved areas that there is really no effective way to move the pieces around until we solve that fundamental problem. And I think we have to be creative to do both because obviously there is not unlimited resources. We don't have the ability to just keep adding. We have a deficit issue we need to tackle. And so we need to deal with those types of creative things. And I think those kinds of answers are going to come in the bigger answer of how we are going to effectively redefine this healthcare system, to develop a marriage or partnership between those regional medical centers you referred to, safety net facilities, and those rural facilities, and partner with all the other, not only physicians but other healthcare providers that are out there providing these types of resources, there is going to ultimately have to be a different type of system developed so that we can really reallocate resources within a very limited system itself.

Mr. DAVIS. Ms. Sorensen.

Ms. SORENSEN. I think one of the most beneficial incentives that we have had really, for example, the meaningful use incentive, that pushed a lot of facilities into getting to the medical records so that we can get where we need to go. We are a long ways from getting where we need to go. But there was at least the jump into that. For us, from the telehealth perspective, for example, our e-Emergency that we have, so we have that board-certified ED doc at the push of a button in our ER 24/7. And it was a huge recruitment tool for us. We have recently recruited a family practice physician that will join us next year. And much of that is the comfort of knowing there is somebody there to support them. They are not practicing completely independent.

So much of what Mr. McDermott mentioned earlier in terms of maybe incentivizing with loans or some type of an arrangement, in the State of Nebraska, we are looking at trying to help with student loans and contracts early on for recruitment purposes and incentivizing them for the services to our communities.

Ms. SAIA. I don't know that I have anything additional to add in regards to incentives for recruiting. What has worked in our facility is being a rural area, where, upon graduation, there is a loan forgiveness for coming to our area. And that has worked for two of our doctors, one of our doctors, and three of our midlevels for reimbursement for staying in the area. What we have tried to do, though, is just have a great community and a great facility to work

in where they want to stay after those 2 years. And that has been successful for us.

Dr. DERKSEN. I would just like to say that I don't know about the MedPAC testimony that was provided last week related, but our evidence in New Mexico and Arizona is that when you train health professionals in rural areas, they are much more likely to go. In fact, when we decentralized our family medicine training and our dental residency training to include rural experiences, we doubled or tripled the rate of retention of practitioners going into practice there. It works for nurse practitioners. It works for dentists. It works for physicians. It works for allied health professionals. I think the evidence is incontrovertible. We have to invest in that health professions training infrastructure to move the health professions training pipeline closer to the areas of need.

Mr. DAVIS. Thank you, Mr. Chairman.

Chairman BRADY. Thank you, Mr. Davis.

Mr. DAVIS. I thank you for the indulgence.

Chairman BRADY. My pleasure.

Ms. Jenkins, you are recognized.

Ms. JENKINS. Thank you, Mr. Chairman.

And thank you to the panel for being here today. A special thanks to Ms. Saia. We both hail from the great community of Holton, Kansas. I am sorry Senator Roberts isn't here. We could all join in the Holton fighting wildcat song. We appreciate the good work that you do, running our hospital, Critical Access Hospital. The community is only about a little over 3,000 folks. And so the hospital is key to the success of our community.

And there are few issues that I hear more about at home than ensuring access to quality, accessible, rural health care. And I believe this hearing is a very important step forward in addressing the problems that providers and patients face in rural America.

Carrie, in your written testimony, you speak about the damaging effects that CMS' direct supervision requirement for outpatient therapy services would have on hospitals like Holton Community Hospital. And you mentioned your support for H.R. 2878, the legislation that I have introduced on that matter. One example that you gave of a routine outpatient therapy service is intravenous infusion. Drawing on your nursing background, can you briefly describe what kind of patient might need an infusion and the process involved for the attending medical professional?

Ms. SAIA. I would be happy to. There is a wide variety of examples. The one that comes to mind is a patient that is suffering from rheumatoid arthritis. They need an outpatient infusion for their medical condition. So they have been seen by their primary doctor. They have been referred to a specialist that comes to our facility and orders a medication. That infusion is usually one time a week for the course of 6 to 8 weeks. And they would come in and need that infusion given intravenously. Another example could be blood component therapy or chemotherapy drugs are also different examples in regards to that.

Ms. JENKINS. Okay, perfect. Thank you. Could you also describe the added burden that direct supervision puts on physicians and ways in which other hospital services suffer because of it?

Ms. SAIA. With direct supervision, the regulation speaks to requiring a physician being readily or immediately available. So if that physician is involved with—Thursdays, we have stress tests in our facility. And a physician has to be physically present and cannot do anything else. So for that physician then to not be able to meet the requirement for direct supervision, if a patient is getting that infusion on that day, that would mean two doctors then would be tied up, one doing stress tests, one doing the outpatient infusion. And then what would suffer would be the care of just normal care in our primary clinics because we have two providers, two doctors tied up doing those two services.

Ms. JENKINS. I see.

Ms. SAIA. If that makes sense.

Ms. JENKINS. It does. Before CMS announced that it was going to enforce the direct supervision rule, were nonphysician providers at Holton Hospital able to administer outpatient therapy services effectively without direct supervision?

Ms. SAIA. They were. We have five different midlevels. They are all trained in advanced trauma life support, advanced cardio, CPR, advanced life support, trauma courses. They provide coverage for our emergency department. But, yet, with this regulation, they are not able to provide coverage for a person on an outpatient basis receiving an infusion.

Ms. JENKINS. Okay. Thank you.

I want to touch on another topic. Ms. Saia probably knows that Holton Community Hospital provides hospice services for folks who are very ill and likely near the end of their life. In fact, my own father spent his final days under the care of the hospice at Holton Community Hospital. And we find that patients are at their most vulnerable at that stage. And I worry that folks in rural areas may be limited by the fact that Medicare's list of authorized hospice providers is not as inclusive as it should be. And this could lead to gaps in access to those who may need hospice but are unable to get it.

And I have introduced legislation, along with Mr. Thompson here on our subcommittee of California, which would recognize physician assistants as attending physicians to serve hospice patients. And I am just curious, maybe Ms. Sorensen and Ms. Saia, do you think that this legislation would help? And I am getting gavelled down. Maybe if you could——

Chairman BRADY. Yes, briefly would be great.

Ms. SAIA. I think it is being very futuristic and very supportive of trying to keep the hospice patient in their local community to receive that, important services, at a very critical time instead of having them leave their local community to receive it elsewhere. We are fortunate to have a medical physician right now available for that. But looking at the future and knowing the shortages, not only hospice, home health, DME, those type of services really could be supported with this legislation.

Ms. JENKINS. Thank you, Mr. Chairman.

Chairman BRADY. Thank you. No one ever calls my legislation futuristic and visionary, so congratulations.

Mr. Pascrell, you are recognized for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman.

And I want to thank the panel for being so forthright. I want to remind the panel, as well as the Members of the Committee, Mr. Chairman, that on June 22, when we had our last hearing, Dr. Mark Miller was with us from MedPAC, gave us a report. And in that report, 80 percent of rural hospitals that have completely closed their doors are located in States that have not expanded Medicaid, et cetera, et cetera, et cetera. You know, we need to take the time to read the stuff that gets to us, Mr. Chairman. That is my point. Because I think many times, as Mr. Joslin says, you have got to get to the fundamental problems and ones that we do not want to address.

So I agree that access to health care in rural areas is an awesome issue. It is worthy of the committee's focus. I come from North Jersey where the closest rural area is more than a stone's throw. But I ran point on rural hospitals in South Jersey. I am very proud of that record. Every day our New Jersey hospitals face challenges associated with serving urban populations. Medicare beneficiaries and other patients living in urban areas need access to quality health care, to provide economic opportunity, ensure community vitality, just like residents living in rural areas. I want everybody to be healthy. And I assert that access to care cannot only be measured by how long it takes you to drive to the nearest hospital or the nearest clinic, isolation from transportation services in urban areas can be just as prevalent and is, in reports that I have seen, as in rural. In my home town of Paterson, New Jersey, which is the third largest city in New Jersey, local hospitals care for a population where 29.1 percent of the residents are living below the Federal poverty level—that is a problem—where the medium household income is $32,707—that is a big problem—and 62.5 percent of the households speak a language other than English. These issues, along with a number of others, like patient mix, a reduction in the disproportionate share of hospital payments, which we had in New Jersey, pose very real challenges for urban hospitals.

But despite these challenges, urban New Jersey hospitals cannot receive any of the add-on payments that rural hospitals are eligible for. If we are going to look at this, let's look at it across the board. The State of New Jersey does not have any hospitals with Critical Access Hospital, Medicare Dependent Hospital, or Sole Community Hospital designations.

Mr. Joslin, in your testimony, you painted a good picture of what your hospital's patient population looks like. Despite the fact that your hospital is located in a rural area, it is actually very similar to the patient population at St. Joseph's Hospital in urban Paterson, New Jersey. I compared it. You mentioned high rates of poverty, low education levels, and limited English. Can you discuss some of the challenges associated with this patient population?

Mr. JOSLIN. Certainly. And your example is absolutely perfect. When you are looking at urban hospitals, their safety net providers in economically challenged areas, it is tremendously difficult to provide all those services that you need. In our area, a third of the adults don't graduate high school, a third. You know, a third of the children in our area are living at or below the poverty level. Twenty percent of the population doesn't speak English. We are in a

huge metropolitan area, relatively speaking, Fresno County and the outlying areas. And there are tremendous challenges.

So we have in common what these rural hospitals have in common, thin operating margins. And we live on the edge financially because there is not a lot of excess in the system of what we deal with, same thing that you are dealing with in your area. So we have to be very efficient. We have to cooperate with others. We have to take an integrated delivery approach to this so that if there are issues with transportation, for example, we can't just admit a patient to the hospital, discharge them, and say, "Okay, now go your way because there are all these resources out there for you." We have to help provide all those additional resources, transportation, getting them to and from, skilled nursing facilities, home care, hospice, all these things we have to help facilitate as well. Because the challenge is—and we had $180 million last year in uncompensated health care, similar probably to what your hospitals have.

Mr. PASCRELL. Yes. Mr. Chairman, just one more statement before I yield.

Chairman BRADY. Quickly please.

Mr. PASCRELL. We want to be fair to everybody. I want to be fair to everybody. What I want folks to know, I am never going to vote for any help for rural hospitals unless, instead of going into the pocket we already have and, therefore, those hospitals suffering, we need to expand the pocket. We need to expand Medicaid. And that is really at the bottom of many of the problems—you talked about getting to the fundamental problems. That is what I think we need to do.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you, Mr. Pascrell.

I would point out, I think hospitals are struggling with the $700 billion of cuts to Medicare, many of which landed on our community and rural hospitals. And they have been feeling damaged for quite some time. Today's hearing, I understand the point of Medicaid expansion, but the point today was really about listening to specific challenges they face and some proposed bills, bipartisan bills, we hope can help eliminate some of those concerns.

So, Mrs. Black, you are recognized.

Mrs. BLACK. Thank you, Mr. Chairman.

Thank the panel for being here.

Mr. Chairman, I would like to ask unanimous consent to submit a letter from the Equal Pay for Equal Care Coalition on behalf of the Tennessee Hospital Association concerning the hospital area wage index for the record.

Chairman BRADY. Without objection.

[The information follows:]

EQUAL PAY FOR EQUAL CARE (EPEC) COALTION

States Concerned with the Unfair and Abused Hospital Area Wage Index Formula

The Alabama Hospital Association, 770 Washington Ave, Suite 290, Montgomery, AL, 36104, 334.834.3477

July 27, 2015

Chairman Kevin Brady
Representative Jim McDermott
Health Committee of the House Ways and Means Committee

Dear Chairman Brady and Representative McDermott,

Since 2014, representatives from the hospital associations of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Western Pennsylvania, Tennessee and Texas have been working together as the Equal Pay for Equal Care (EPEC) Coalition to address concerns and issues with the Medicare hospital area wage index (AWI).

On behalf of the hospitals and health systems represented by the EPEC Coalition, we are writing to ask for Congress' help to fix the flawed and unfair AWI.

The original intent of the AWI adjustment was to ensure Medicare payments reflected market-to-market differences in hospital labor and benefit costs. Because the AWI is budget neutral, the increased payments to one area result in decreased payments to others. The reality of the current system is continuing reductions in Medicare payments to the large majority of states, which have all seen increases in labor costs but not as large as a handful of states that experience increases in Medicare payments every year. The chart below shows how AWI levels for EPEC states consistently have decreased over the years and are projected to continue in the future because of the offset to other states.

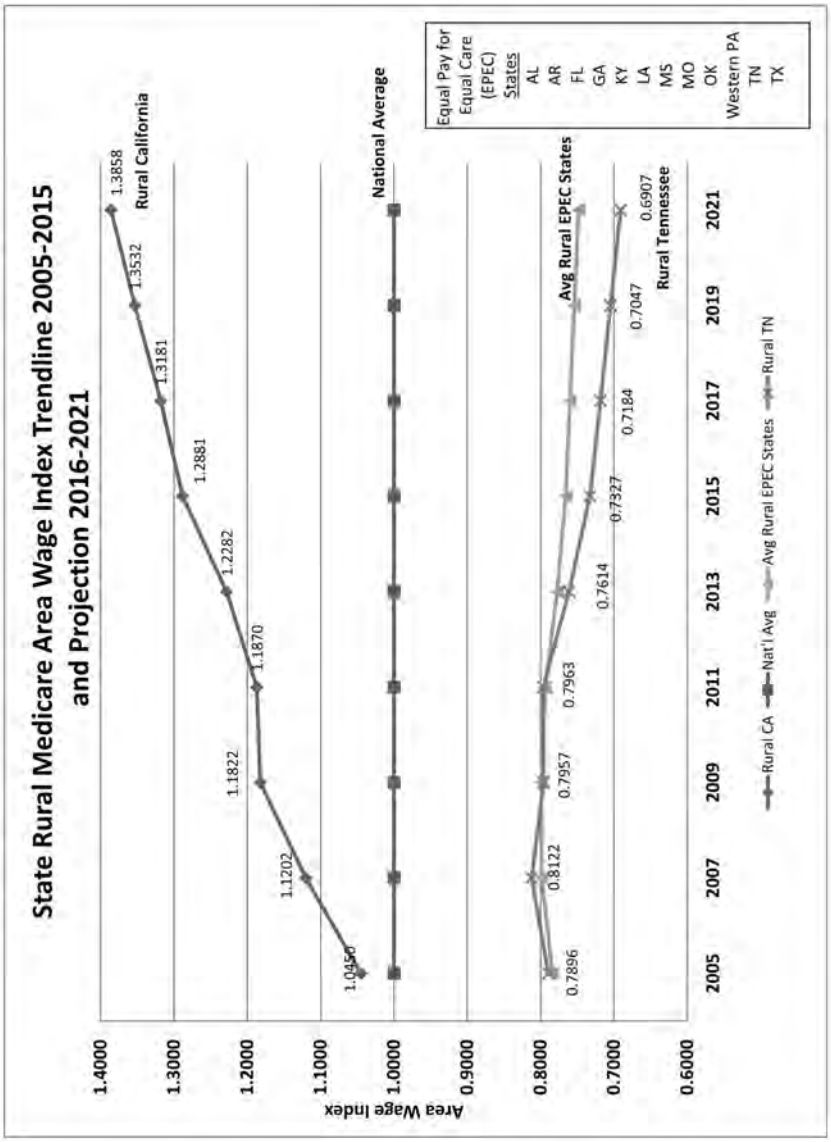
It is widely recognized in the healthcare industry that comprehensive reform of the AWI is greatly needed. In fact, the Medicare Payment Advisory Commission (MedPAC) recommended repealing the system in 2007. However, to date, no action has been taken. This inaction has facilitated the continuation of political manipulation and one-time "fixes" that further distort the original intent of the AWI. Further, it threatens access to care in states that effectively have managed costs by placing them in a death spiral of decreasing reimbursement for the exact same care that is delivered in higher reimbursed states. The growing disparity between the "have" and "have not" states increases every year, which makes swift congressional action vitally important.

This matter becomes more urgent every year because of reimbursement reductions mandated in the Affordable Care Act (ACA) and sequestration pursuant to the Budget Control Act of 2011. Coupled with these additional financial pressures, the continued trajectory of the AWI for our states is unstainable.

Thank you for your attention to this important issue.

EPEC MEMBER STATES

Alabama	Georgia	Mississippi	Western Pennsylvania
Arkansas	Kentucky	Missouri	Tennessee
Florida	Louisiana	Oklahoma	Texas


State Rural Medicare Area Wage Index Trendline 2005-2015
and Projection 2016-2021
Area Wage Index
1.4000
1.3000
1.2000
1.1000
1.0000
0.9000
0.8000
0.7000
0.6000
2005
2007
2009
2011
2013
2015
2017
2019
2021
Rural California
1.3858
1.3532
1.3181
1.2881
1.2282
1.1870
1.1822
1.1202
1.0450
National Average
Avg Rural EPEC States
0.7896
0.8122
0.7957
0.7963
0.7614
0.7327
0.7184
0.7047
0.6907
Rural Tennessee
Equal Pay for Equal Care (EPEC) States
AL
AR
FL
GA
KY
LA
MS
MO
OK
Western PA
TN
TX
Rural CA
Nat'l Avg
Avg Rural EPEC States
Rural TN

Mrs. BLACK. Thank you, Mr. Chairman.

Mr. Derksen, I appreciate your testimony on the acute financial pressures that rural hospitals face because of onerous Medicare regulations and cuts in reimbursement. As you point out in your testimony, for hospitals and rural States, like Tennessee, the risk of closure is real. I represent, about 50 percent of my district is rural, so we have a lot of those hospitals that are sitting in that situation.

But I would like to bring up another challenge that is adversely impacting Tennessee hospitals, which is the Medicare hospital wage index. This issue hasn't received as much attention as those that have been identified in your testimony. But I believe that it will be receiving more and more attention in the near future as it negatively impacts these hospitals and potentially will mean closure for them as well, unless that reimbursement is changed. And although the area wage index is intended to ensure that Medicare hospital payments reflect the geographic differences in wages, many, including myself, believe that the system is broken.

In fact, we had an exchange last week with MedPAC's executive director, Mark Miller, in which he agreed that the area wage index is neither accurate nor fair, and it needs to be repealed. So the area wage index is having an adverse impact on hospitals in Tennessee and other hospitals in rural areas. Thus, this letter that I am going to be submitting, which has a whole coalition of hospitals that are represented, mostly rural areas, all over the country. These hospitals have seen the area wage index levels rapidly decreasing over the years, while the levels for a handful of the others have been increasing. So I know this is going to be a difficult topic because some have seen significant increases, while others have seen significant decreases.

And would you talk about repealing this wage index and replacing it with a more accurate and fair system that would help to relieve some of those financial pressures specifically on those rural hospitals that are in this situation?

Dr. DERKSEN. Mr. Chairman, Representative Black, thank you for bringing up this issue. This is a crucially important issue in some parts of our country, including the area I work in in Tennessee obviously. I think we do need to bring some rationality to this. I think we need to bring some fairness. And I certainly appreciate your leadership on this issue. But there are complicated issues that need to be ironed out. And I admire the courage to bring this forward. Because whenever there is winners and losers, the stakes and the fights get pretty intense.

But I think the issue is there shouldn't be winners and losers where large swaths of the United States, where 20 percent of our population lives, are basically forced to accept these very low payments. I don't think it is just with the Medicare area wage index. I think there are some issues related to graduate medical education payments that are very, very low. When I was in New Mexico, we had the lowest per-resident amount. Why in the world, you know, is Connecticut or New York hospitals being paid nine times per capita what Texas is being paid for Medicare GME? I think the work that you have done in a bipartisan manner in this committee is exactly the kind of leadership we need. And I think that the

types of things that you have proposed and have been talking about are, it is time for us to address these issues and to make this a much more rational policy. Thank you.

Mrs. BLACK. You are welcome.

One other issue, and I know I am not going to have enough time to really ferret this out, but I would like for the panelists, if they have an opportunity, to respond back in a written form about being able to use ACOs in rural areas.

My colleague, Mr. Thompson, did hit on something that we are working on together on the telehealth, but also what are the barriers for using the Accountable Care Organizations where we could have more coordinated care? I know that we are seeing those maybe be successful in the bigger urban areas. But I would like to hear from you about where you believe that the barriers might be in also using ACOs, where we could actually have those alternative payment models and be able to coordinate the care. So if you could just let me know or let the panel know what is hampering those efforts, we would really appreciate hearing from you. So that would be another area we might be able to help our rurals in.

Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Great. Thank you.

Mr. Kind, you are recognized.

Mr. KIND. Thank you, Mr. Chairman. Thanks for holding this hearing.

I want to thank the witnesses for your testimony, your patience today. And just to follow up on that last point, I am glad Mrs. Black raised this issue, it was actually a question I was going to ask you in regards to challenges you face with ACOs, the implementation in rural areas. I hail from the State of ACOs. My healthcare providers throughout Wisconsin have been practicing a more integrated, coordinated, patient-centered healthcare delivery system for quite some time. What I am hearing from my Critical Access Hospitals, a lot of rural providers, is that there are some unique challenges that they face with the ACO model, medical homes, that more coordinated care. So anything you can provide our committee to provide some insights because I have been reaching out to my providers back home on this as well.

Clearly, that is the direction that the Affordable Care Act is trying to drive the healthcare system, to more coordination, more integration in healthcare delivery services. But there are unique challenges that we recognize in rural areas. And that needs to be addressed as well.

Let me shift and address a topic that hasn't been addressed yet today. Maybe you might provide some insights. Clearly, there has been increased consolidation in the healthcare industry in recent years. We are seeing more consolidation, with the bigger providers coming into rural areas, buying up hospitals and clinics. We are also seeing a huge amount of consolidation with health insurance companies right now. Obviously Cigna and Aetna are the latest in the news right now. But I wanted to get anyone's reaction on the panel today and these trends that we are seeing, the impact it could have on rural healthcare providers, both the access and the quality issues, if you would like to share with us today.

Dr. Derksen.

Dr. DERKSEN. Mr. Chairman, Representative Kind, I think where integration and consolidation results in quicker access to health care, to high-quality health care, or it reduces the rate of cost growth, or it improves health outcomes, and those are measurable health outcomes, I am all for it.

When integration and consolidation means fewer choices for providers, for patients, and it increases the costs, I think we ought to look at those types of issues. And that is where I am kind of worried. In States where there is robust competition, for example, in the health insurance marketplace, such as Arizona, we have at least seven insurers offering 70 different plans in our 13 rural counties. That is a lot of competition. As a result, our premiums went down for silver plans 10 percent. I think the marketplace can work, but it requires robust competition. I have noticed in other States with only one or two insurers, that those rates go up. And there is these kind of endless requests for increases in premiums. So I think there is some advantage to bring it together. I think rural communities and our community hospitals are looking to partner in ways through telemedicine, telepsychiatry, through teleradiology, and other mechanisms. We ought to encourage that. But let's keep the end in sight here. We want high-quality care. We want ready access. And we want to control cost growth. And if those three criteria are met, then that should be kind of our litmus test to me.

Mr. KIND. Mr. Joslin.

Mr. JOSLIN. I think fundamentally the system is fragmented and broken. And I think you are seeing consolidations not for business purposes but for patient care purposes. And I think the only way we are going to fix this healthcare system is to partner together and develop new models that are much more effective in treating patients. If you do the same thing over and over and over again, obviously, you are not going to get different results. We have to get creative and look to doing things differently. So what I look forward to sharing with you in the coming months are a pilot that we are doing, for example, where we, in a large urban area, are partnering with a large provider in the rural area to develop an integrated network with access to care, I absolutely agree with you, access to care, the primary driver in this, to make sure there is a system there for everybody, regardless of resources, that is available close to where those patients are, and provides the different level of resources they need. But it has to be this new level of partnership if the mission is correct. And the mission has to be accessed to high-quality, affordable health care. And so you are going to see lots of these models pop up. Some will be good. Some won't be so good. But we need to learn from all of them and continue to work towards developing a better model.

Mr. KIND. I would agree with both of those things.

Mr. Chairman, this might be another topic ripe for a future hearing, as there are large forces taking place in the healthcare field and consolidation, both on the provider and the insurance side. And we are going to have to provide more oversight.

And, finally, on the training aspect, Mr. Joslin, you talk about the importance of training in rural areas. I know, in Wisconsin—this might be true in your areas too—we are really making a con-

certed effort to try to recruit in rural areas before even training because we have found if we can get them from the rural community, from the quality of life they grew up in, it is easier to direct them back into those communities to serve in the healthcare function.

So if you have got some unique programs that you have been working on as far as recruitment, we would be interested in hearing about that so we can take that to capacity.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you, Mr. Kind.

Mrs. Noem, you are recognized.

Mrs. NOEM. Thank you, Mr. Chairman.

And thank you for allowing me to take part in this hearing. I am not a normal member of the Health Subcommittee. But I represent South Dakota. And I have the entire State. So there is not much in South Dakota that isn't rural and doesn't face a lot of the challenges that you all have been discussing today.

And I am glad that Mr. Kind touched on that because that was something I was going to point out that Mr. Derksen talked about earlier, was the fact that when you train physicians and caregivers in rural areas, they tend to come back. We have a very difficult problem with recruiting physicians to some of our communities in South Dakota. But we have noticed that if we have the training in those communities, if we have residencies available, that that makes a world of difference.

So I want to thank you for discussing that today and putting that in the record because it is important to make sure that we have the kind of access to care that we need. And we have that by making sure there are physicians in the area. And I have visited many, many of the rural hospitals in South Dakota. I have seen the necessary care that they provide to our population and the people that live in my home and the patient population that they serve. In fact, a lot of my rural hospitals feel that many times they are treating patients that may be sicker, that may be older. We have a very—our population is much older than I think, on average, than some other States. And they feel like they have more challenges because of that than some of their urban hospital counterparts. And they outlined a number of the challenges that they face.

And Congress and the administration have agreed that access to care is limited in these areas and communities. And people have to travel farther to get the kind of checkups and emergency services they need. And this can significantly increase the cost of health care and impact outcomes in emergencies when time is critical. In fact, research shows that rural residents travel twice as far to the closest emergency room than urban populations do. Rural communities face demographic challenges both with the Medicare population and the community population at large. You have discussed many of these issues today. And as a result of all of these challenges, a lot of our rural hospitals are operating at a financial loss. So what concerns me is how we will keep access to care in these parts of the country. And there are many things that Congress can do, and there are many proposals and bills that are filed. I would like to know from each of you what your biggest challenge is at keeping that access to care in those rural communities and

a suggestion of what Congress, it may be a payment system, it may be a reimbursement formula, it may be different policies or regulations that cost you so much money in complying with them rather than delivering care to patients. What is your biggest challenge that Congress could immediately address that would be a relief to our rural community hospitals?

We will start with Mr. Derksen.

Dr. DERKSEN. Mr. Chairman, Representative Noem, thank you for bringing up these issues. I think it is very important. I spent a lot of years trying to figure out ways to get health professionals trained and ready to practice in rural areas. And I mentioned one of them. I think the thing before us now pragmatically that we could invest in is graduate medical education. And maybe the leverage point there, as we expand Medicaid in at least 30 of the States so far, is to use Medicaid graduate medical education where States have far more flexibility, through State plan amendments and such, of supporting a rural health professions infrastructure.

But the second thing has been mentioned several times, there is no greater thing that a Governor can do is to reduce the uncompensated care. If you just shift uncompensated care cost to someone else, that is a hidden tax, every bit as important as any other kind of tax you might levy. And in Arizona, we are the very last State to do Medicaid. You know, that was passed in 1965 as part of an amendment to the Social Security Act. We didn't get around to it for 17 years in Arizona until 1982. But we did expand Medicaid to 100 percent of the federal poverty level. We were an early expansion State. But we had to freeze that. 200,000 people got forced off of Medicaid during the Great Recession a couple years ago. And what happened is the uncompensated care costs for our hospitals doubled and tripled and have put many to the brink of fiscal extinction. Governor Brewer, not to be confused with a progressive, you know, Democratic Governor, very conservative, somehow she restored that coverage back to 100 percent. And while she was at it, being very unpopular with her conservative colleagues, expanded it to 138 percent. That single factor of getting people health coverage, a payment source, has brought—in 2013, half of our Critical Access Hospitals had negative margins. Now they are just barely above the positive margin, but they are in positive. Getting people coverage is there. Every State does it different.

In Arizona, we do it as the Arizona healthcare cost containment system. But it is a way to go about assuring accountability. Every State is going to have to sort through how best to cover their uninsured. And I think that factor alone is probably the most important for our rural hospitals and our rural providers.

Mrs. NOEM. But not necessarily something that Congress can do.

Dr. DERKSEN. Pardon me?

Mrs. NOEM. Not necessarily something that Congress can make a decision on today.

Dr. DERKSEN. I think any time you are looking at Medicare and Medicaid coverage, you can't really separate them easily. But the types of policies that you are doing here, the types of payment issues—the hospital, I mentioned that we will close on Friday because Medicare has frozen payment, well, Medicaid can't pay them

in our State either. So a lot of these issues go hand in hand. Thank you.

Mrs. NOEM. Mr. Chairman, I realized I am out of time. If the rest of the panelists wouldn't mind submitting to me your recommendations on what you believe are the biggest challenges to maintaining access to care in rural communities, I would certainly appreciate that.

With that, I yield back.

Chairman BRADY. Thank you. I would like to thank today's witnesses for their testimony today. And I appreciate your continued assistance getting answers to the questions that were asked by the committee. As a reminder, any member who may wish to submit a question for the record will have 14 days to do so. If they do, I would ask the panel to respond in writing in a timely manner.

Again, we are looking for common ground in how we address these rural healthcare disparities. Today's hearing was helpful.

With that, the committee is adjourned.

[Whereupon, at 11:45 a.m., the subcommittee was adjourned.]

[Submissions for the record follow:]

WRITTEN STATEMENT OF THE
AMERICAN ASSOCIATION FOR HOMECARE

SUBMITTED FOR THE
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
HEARING ON RURAL HEALTH
JULY 28, 2015

American Association for Homecare
1707 L St NW, Suite 350
Washington, DC 20036
Phone: 202-372-0107
Fax: 202-835-8306

WRITTEN STATEMENT OF THE
AMERICAN ASSOCIATION FOR HOMECARE

SUBMITTED FOR THE
HOUSE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH
HEARING ON RURAL HEALTH
JULY 28, 2015

The American Association for Homecare (AAHomecare) is pleased to provide its views on the rural health care disparities created by Medicare regulations to the House Ways And Means Subcommittee on Health.

AAHomecare is the national trade association for home medical equipment (HME) providers, manufacturers and other stakeholders in the homecare community. AAHomecare members serve the medical needs of Americans who require home oxygen therapy, mobility assistive technologies (standard and complex wheelchairs), hospital beds, diabetic testing and medical supplies, inhalation drug therapy, home infusion and other home medical products, services and supplies.

Membership reflects a broad cross-section of the homecare community, including providers of all sizes operating approximately 3,000 locations in all 50 states.

AAHomecare strongly recommends that Congress preserve and strengthen access to home medical equipment for the millions of Americans who require medical care in their homes. In particular, we ask that Congress protect access to home medical equipment in rural areas by preventing the use of prices derived from the Medicare competitive bidding program, which has been recognized as flawed by well over 200 economists, computer scientists, statisticians and auction experts from around the world. These rates do not reflect the true cost of business in rural areas, where fewer providers serve larger areas and face higher delivery and associated service and repair costs.

To do so otherwise, would force the closure of many home medical equipment providers in these areas, cost jobs in an economy that cannot afford to lose them, and deprive a growing number of patients, many of whom are seniors or people with disabilities, access to the equipment and services they need to receive medical care in their homes.

Background

Cost Effectiveness of Homecare

HME offers an efficient and cost-effective way to allow patients to receive care they need at home. The need for HME and HME providers will continue to grow to serve the ever-increasing number of older Americans. Homecare represents a small but cost-effective portion of the more than $2.3 trillion national health expenditures (NHE) in the United States, and approximately 15.5 million Medicare beneficiaries require some type of home medical equipment annually, from bedside commodes for people who have hip replacements to high-tech ventilators for quadriplegics.

Yet, not all products are equal: some require licensed or credentialed clinicians to be on staff or cost $15,000 just to procure. While past reports from Congress and the Office of Inspector General (OIG) shed light on products they believe to be overpaid, many others are unprofitable for providers to provide even before the bidding program. The high cost of fuel, labor, rent and utilities, and regulatory compliance associated with billing and collections, HIPAA privacy, identity theft, IT security, Sarbanes-Oxley, waste disposal, beneficiary and employee safety, OSHA, DOT and FDA regulations continues to escalate year after year. Anyone who has ever required HME or had a relative who needed it can attest that our service includes much more than just the equipment.

With greater access to quality equipment and services at home, beneficiaries and Medicare will spend less on hospital stays, emergency room visits, and nursing home admissions. Home medical equipment is an important part of the solution to the nation's healthcare funding crisis. The facts bear this statement out as private health care plans have contracted for our services for decades and reaped the cost-savings along the way. Even the current Administration is trying to develop programs to manage chronically ill Medicare patients in the home through new demonstration projects and the Innovation Center.

One key fact that is sometimes lost in this debate is that HME represents about one percent of annual Medicare spending. So while this program appears to reduce HME expenditures when simply comparing past and current Medicare Part B expenditures, CMS has not examined the cost shifting that occurs as a result of the program as more beneficiaries will be forced to receive care in hospitals, nursing homes, and emergency treatments.

Impact on Rural Areas

The problems with competitive bidding are already well known from the experiences in the original Round 1 and Round 2 areas. Soon, these impacts will be expanded to suppliers and beneficiaries in the small towns and rural areas outside of the original bid areas. These rural home medical equipment providers are in danger of being hit with devastating Medicare cuts that will hurt patient access to HME, close businesses and cost jobs.

On October 31, 2014, the Centers for Medicare & Medicaid Services (CMS) released the final rule on "Medicare Program: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies," which establishes the methodology for making national price adjustments to payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) paid under fee schedules.

Data used to calculate the fee schedule was based upon information gathered from the DMEPOS competitive bidding programs (CBPs) and phase in special payment rules in a limited number of competitive bidding areas (CBAs) under the CBP for certain, specified DME and enteral nutrition products.

For qualified DME items, the final rule phases in, over 6 months, a new reimbursement rate for non-CBAs. On January 1, 2016, the reimbursement rate for these claims (with dates of service from January 1, 2016 through June 30, 2016) will be based on 50 percent of the un-adjusted fee schedule amount and 50 percent of the adjusted fee schedule amount which will be based on the regional competitive bidding rates.

Starting on July 1, 2016, reimbursement rate will be 100% of the adjusted fee schedule amount which will be based on regional competitive bidding rates. The following are examples of these drastic cuts –

HCPCS Code	Region	Current	1/1/16 rate	7/1/16 rate
E1390 (O2 concentrator)	Mideast	$178.23	$134.21 (-25%)	$90.18 (-49%)
EO470 (BiPAP)	Rocky MT	$241.85	$178.50 (-26%)	$115.14 (-52%)
K0003 (standard wheelchair)	Great Lakes	$97.98	$68.78 (-30%)	$39.58 (-60%)
K0823 (standard PMD)	New England	$568.89	$424.22 (-25%)	$279.55 (-51%)

The application of payment rates, set by CMS's flawed competitive bidding process, to non-CBAs will disrupt Medicare beneficiaries' access to the DME items they need. In CBAs, suppliers are forced to accept contracts for

DME items at a lower rate with the knowledge that there will be a limited number of suppliers that can provide service and supplies in that bid area. Suppliers then try to make up for the drastic payment cuts through increased volume of beneficiaries served in that CBA blended with the higher payments from beneficiaries served outside of the CBA. As a result of CMS' final rule, suppliers in non-competitive bid areas will receive the same drastic payment cuts set in CBAs, without exclusive contracts and increase in volume of business or the ability to compensate with higher rates outside of the CBA. The industry also has convincing data that indicates providing DME items in rural areas have a higher cost than in urban areas.

CMS' final rule also limits the bid ceiling for future rounds of competitive bidding to payment rates set by previous rounds of bidding. Currently, bid limits are set by the fee schedule, which allows for adjustments for inflation. CMS has indicated that it plans to continue competitive bidding for DME items far into the future. Decreasing the bid ceiling limit over many years, while medical inflation continues to rise, will set artificially low rates, which will hamper competition. Ever decreasing bid limits will make it impossible to set market prices through an auction process, without negatively impacting beneficiary care. Congress required CMS to save money compared to the (unadjusted) fee schedules, because taken to its logical conclusion, CMS' plan would eventually result in suppliers paying the government to provide items and services.

Conclusion

Rural home medical equipment providers are in danger of being hit with devastating Medicare cuts that will close businesses and cost jobs.

AAHomecare strongly urges the Committee to take action to prevent these drastic cuts and protect access to home medical equipment for seniors and people with disabilities in rural areas.

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The American Association for Homecare represents providers of home medical or durable medical equipment and services who serve the needs of millions of Americans who require prescribed oxygen therapy, wheelchairs, enteral feeding, and other medical equipment, services, and supplies at home. Visit www.aahomecare.org.

AANP | American Association of NURSE PRACTITIONERS™

The Voice of the Nurse Practitioner®

August 11, 2015

Representative Kevin Brady
Chairman
Ways and Means Health Subcommittee
1102 Longworth HOB
Washington D.C. 20515

Representative Jim McDermott
Ranking Member
Ways and Means Health Subcommittee
1102 Longworth HOB
Washington D.C. 20515

Dear Chairman Brady and Ranking Member McDermott:

The American Association of Nurse Practitioners (AANP), the largest full service professional organization representing the 205,000 nurse practitioners (NPs) across the country, applauds the committee for taking the time to examine the rural health disparities created by Medicare regulations. AANP would like to lend its support to a number of legislative efforts which the committee could act upon to improve rural residents' access to care by removing barriers to practice which only increase costs and cause delays in care.

Nurse practitioners have been providing primary, acute, and specialty care for half a century, and are rapidly becoming the health care provider of choice for millions of Americans. According to our most recent survey data, more than 900 million visits were made to nurse practitioners in 2012, a number we anticipate will continue to grow in the coming years. Nurse practitioners provide care in nearly every health care setting including clinics, hospitals, emergency rooms, urgent care sites, private physician or nurse practitioner practices (both managed and owned by nurse practitioners), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics and homeless clinics. It is important to remember that in many of these settings nurse practitioners are the lead onsite provider. In addition to diagnosing and treating acute and chronic illnesses, nurse practitioners emphasize health promotion and disease prevention in the care of their patients. Daily practice includes: assessment, ordering, performing, supervising and interpreting diagnostic and laboratory tests, making diagnoses, initiating and managing treatment including prescribing medication (as well as non-pharmacologic treatments), coordination of care, counseling, and educating patients, their families and communities.

Additionally our data shows that the vast majority of nurse practitioners are primary care providers. Eighty-eight percent are educationally prepared to be primary care providers and over seventy-five percent currently practice in primary care settings. Further, over 174,000 nurse practitioners, nearly eighty-five percent of the current nurse practitioner workforce, are treating Medicare beneficiaries. Nurse practitioners are the health care provider for many of the beneficiaries located in rural and underserved areas.

Administration: PO Box 12846 • Austin, TX 78711 • Email: admin@aanp.org • Website: aanp.org
Government Affairs: 225 Reinekers Lane, Suite 525 • Alexandria, VA 22314 • Email: governmentaffairs@aanp.org

Removing Direct Supervision Requirement for Outpatient Therapeutic Services Furnished in Small Rural Hospitals and Critical Access Hospitals (CAHs)

AANP agrees with all of the witnesses in their support of removing requirements for direct physician/Non-physician provider (NPP) supervision of outpatient therapeutic services furnished in CAHs and small rural hospitals. Removing this arbitrary requirement would allow professionals educated and licensed to provide these vital services to do so without the direct supervision of a physician/NPP. Some of the outpatient therapeutic services impacted by this requirement include drug infusions, blood transfusions, and wound debridement.

AANP would be also support the passage of *the Protecting Access to Rural Therapy Services (PARTS) Act (H.R 1611/S. 257)*. This piece of legislation would not only remove the requirement of direct physician/NPP supervision for outpatient therapeutic services furnished in small rural hospitals and CAHs but would also authorize nurse practitioners to supervise cardiac and pulmonary rehabilitation services. Under current law only a physician may supervise cardiac and pulmonary rehabilitation services even though nurse practitioners are educated and trained to provide these important services that are currently being underutilized due to a lack of access.

Removal of 96 Hour Rule

AANP agrees with removing the current requirement that a physician certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. This requirement creates needless additional documentation and busy work that could be spent on other more important activities in the CAH.

Nurse Practitioners & ACOs

During the hearing multiple Members asked for more information regarding the problems that rural ACOs are encountering. One issue of particular significance to nurse practitioners is that under current Medicare law (specifically the Shared Savings Program), nurse practitioners are recognized as ACO professionals but those patients who receive their care solely from a nurse practitioner within an ACO are by statute, ineligible to be counted toward the ACO's Shared Savings. This barrier requires that a patient who currently receives care from a nurse practitioner within an ACO must be seen at least once each year by a physician within that ACO in order to be counted toward the ACO's Shared Savings. This needless requirement makes it harder to establish and maintain ACOs in rural and underserved areas more reliant on nonphysician providers.

AANP asks that the committee pass legislation that ensures patients seen solely by nurse practitioners within an ACO count toward an ACO's shared savings. In the Senate, *the Rural ACO Improvement Act of 2015, S. 1456* has been introduced and would make this change.

Authorize Nurse Practitioners to Certify Patient Eligibility for Medicare Home Health Services

Another barrier to practice which harms patients and is magnified in rural areas is the current Medicare barrier that prevents nurse practitioners from certifying their patient's eligibility for Medicare home health services. While nurse practitioners are currently authorized to perform the face-to-face assessment of their patient's needs prior to ordering home health services, a physician must certify their assessment even though that physician was not involved in the assessment. This specific barrier was

addressed in Shannon Sorensen's, CEO of Brown County Hospital, written testimony as a requirement which decreased access to their patients.

AANP asks that the committee address this burdensome requirement by passing legislation which would allow nurse practitioners who are authorized to perform the face-to-face assessment be authorized to certify that assessment. *The Home Health Care Planning Improvement Act of 2015, H.R. 1342* makes this change and has the bipartisan support of 136 cosponsors including 14 Members of the Ways and Means Committee. Its companion bill in the Senate, *S.578* has 35 cosponsors.

In closing, we look forward to working with the Committee to reduce rural health disparities created by Medicare regulations. AANP is eager to support the committee's efforts to remove barriers to practice which create delays in care and increase in costs while not improving the care provided to patients. We look forward to working with you in the future. Please contact MaryAnne Sapio, Vice President of Federal Government Affairs at msapio@aanp.org for further information.

Sincerely,

David Hebert
Chief Executive Officer

Administration: PO Box 12846 • Austin, TX 78711 • Email: admin@aanp.org • Website: aanp.org
Government Affairs: 225 Reinekers Lane, Suite 525 • Alexandria, VA 22314 • Email: governmentaffairs@aanp.org

August 11, 2015

The Honorable Kevin Brady
United States House of Representatives
301 Cannon House Office Building
Washington, DC 20515

The Honorable Jim McDermott
United States House of Representatives
1035 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of the American Association of Teaching Heath Centers (AATHC), I am writing in response to the House Committee on Ways & Means Subcommittee on Health hearing held on July 28, 2015 to discuss rural health care disparities created by Medicare regulations.

Figure 1. Location of Teaching Health Center Programs

Source: Health Resources and Services Administration. Teaching Health Center GME 2014 Grant Awards.

The AATHC was founded in 2013 to represent the interests of Teaching Health Center Graduate Medical Education (THCGME) programs nationwide – currently comprised of 60 HRSA-supported Teaching Health Centers (THCs) that train 690 resident physicians in rural and urban underserved areas in 27 states and the District of Columbia.

First, we wish to again express our deep gratitude for the continued support shown by Chairman Brady, Ranking Member McDermott, and the entire Health Subcommittee. We appreciate your good work in drawing attention to the THCGME program, and look forward to our continued partnership.

During the Health Subcommittee's hearing on July 28 discuss rural health care disparities created by Medicare regulations, we were pleased that the Subommittee highlighted the THCGME program as a possible solution to the primary care shortage that is reaching crisis levels in rural areas of the US. In his testimony, Mr. Daniel Derksen Director of the Arizona Center for Rural Health, called out THCGME specifically as a building block of GME reform. The demonstrated success of the THC model, particularly in rural areas, is indisputable. We are training and producing high-quality primary care doctors for the rural areas that need them most.

Many of these doctors come from the finest medical schools in our country, and the demand for these slots is extremely high. For example, ten programs reported over 11,000 applications from medical students for their 93 residency slots available for the 2014-2015 academic year. Of course, medical students typically apply to multiple residency programs, but the high ratio of applicants to THCGME slots shows that medical students are increasingly interested in THC programs. In the past four years, the number of applicants received by THCGME programs has increased 30 percent.

However, despite the program's overwhelming, documented success, and 2-year extenstion, THCGME programs nationwide are currently on the brink of collapse and the growth of the progam has halted at a time where THCs are just beginning to ramp up to their full complement of residents in order to provide high-quality, accessible, and affordable healthcare in urban and rural areas.

As the result of widespread, bipartisan, bicameral support for the THCGME program, the program was extended for 2 years and $120 million in H.R. 2, the Sustainable Growth Rate (SGR) "fix" legislation. This additional funding was intended to enable the THCGME program to not only continue training residents and providing care in rural and urban underserved communities, but also lay the foundation for meeting future healthcare workforce needs.

This Republican-led, bipartisan legislative victory demonstrates the widespread impact of the THCGME program and the strong desire of key legislators to see the program not only endure, but also to grow and expand in order to provide well-trained primary care physicians in areas that need them most. Certainly, urgency exists to ensure HRSA implements the funding provided in a way that maintains these programs and continues delivering doctors to communities where they are most needed. Currently, a reduced per resident amount (PRA) is threatening not only the completion of training for many current residents, but also the admission of new residents into training. Without the extension of funding, many of these vital programs are being forced to make the difficult decision to stop accepting residents, or shut down completely.

The traditional method of residency training, funded primarily by CMS under a Medicare formula, is mainly focused on hospital-based training and the profile of physicians trained no longer matches the nation's needs – too few enter primary care and even fewer choose to practice in rural or underserved locations. In contrast, the THC model uses community-based ambulatory health centers, such as nonprofit community health centers and community consortia, to train primary care residents who will practice twenty-first century care in underserved communities both during their training, and after their residencies have been completed.

According to the American Academy of Family Physician, by 2025, the United States will require an additional 52,000 primary care physician, and the shortage is being felt most deeply in health professional shortage areas (HPSAs) and medically underserved areas (MUAs). As many as 60 million people living in these areas experience disparities in health care access either because they are uninsured, or because they live in rural, urban, or suburban areas without enough primary care physicians. Additionally, we are reaching a critical time, when the number of medical school graduates will be greater than the number of residency slots. Without a residency medical school, graduates are unable to obtain a medical license.

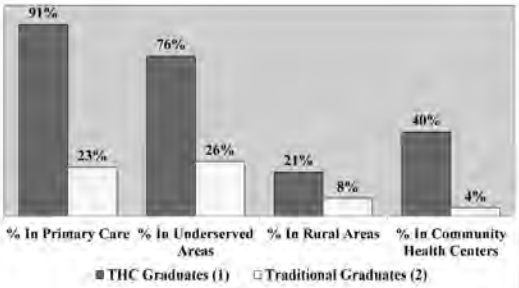
While it is too early for a full assessment of the THC program, preliminary analyses demonstrate positive and promising results and signal that this innovative model of graduate medical education should continue to be developed and meet its full potential.

During their residency training, THC residents practice in the approved primary care specialties of Family Medicine, General Internal Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry and General Dentistry. These residency practices are located in underserved communities,

expanding access to health care and decreasing health disparities. *A fundamental question is: Do they continue to fill these roles after they complete their residencies?* In July 2014, AATHC conducted a survey after the 2014 academic year to determine where THC graduates ended up after graduating from the THCGME program.

Figure 2 compares the post-residency choices of THC and general Graduate Medical Education (GME) residents. These signal the extent to which, on a longer term basis, THC's newly-minted physicians help address national needs – particularly by providing ambulatory primary care in underserved areas.

Figure 2. What Types of Practices Do THC and Traditional Residents Have After Graduating?



Sources: 1. AATHC survey (2015) 2. Chen, et al. (2013)

The results of AATHC's survey prove that the THC model is working.

- 91 percent of THC graduates remain in primary care practice, compared to about 23 percent of traditional GME graduates.

- More than three times as many THC graduates (76 percent) went on to practice in underserved communities, compared to 26 percent of the traditional graduates.

- Twice as many THC graduates (21 percent) go on to practice in rural areas, compared to 8 percent of traditional graduates.

- About nine times as many decided to practice at nonprofit community health centers (40 percent) as regular medical graduates (4 percent).

- Most (61 percent) of the THC graduates continue to practice in the state where they conducted their residencies. For example, in Texas, a state with a particularly serious primary care physician shortage, 80 percent of those residents who trained in Texas stayed in Texas.

In addition to an increase in demand among institutions and medical students, there is widespread support for this program among Members of Congress, local communities, and key health care stakeholder organizations.

Since traditional CMS-funded residency training continues to produce an inordinate proportion of specialists under their fixed cap at the expense of primary care, the THC model is arguably the single most promising alternative to traditional CMS-funded residency training. In the 2015-2016

academic year, the program will support over 750 residency slots, provide more than 750,000 primary care visits in underserved rural and urban communities, and, perhaps, most significantly to the American tax payer, guarantee that every dollar spent is used exclusively for primary care training.

The uncertainty of future federal funding remains a serious inhibitor to the long-term success of the Teaching Health Center model – the most reliable training model for primary care physicians in underserved rural and urban locations. If the H.R. 2 funding is not front-loaded in the current 2015-2016 academic year to ensure the $150,000 PRA is maintained, it will continue to have a negative impact on the rural communities that the THCGME program serves. It is imperative we secure funding immediately to permanately fund the THCGME program, allowing it to reach its full potential and produce physicians to train and serve in rural areas.

On behalf of the AATHC, thank you for your continued support of this vital program. We look forward to hearing from you, and continuing to work together to ensure the long-term success of the THCGME program.

Sincerely,

Stephen McKernan, DO
Executive Committee, American Association of Teaching Health Centers
Program Director, Conroe Family Medicine Residency Program
CEO, Lone Star Family Health Center

TESTIMONY OF
AMERICA'S CRITICAL ACCESS HOSPITAL COALITION
HOUSE WAYS AND MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
JULY 28, 2015

Chairman Brady, Ranking Member McDermott, and distinguished Committee members, thank you for holding the Rural Health Hearing o discuss rural health care disparities created by Medicare regulations. America's Critical Access Hospital Coalition works with over 150 CAHs across the country to bring together healthcare leaders to discuss innovative, sustainable practices and plan for the future of healthcare in rural America. We would like to offer our testimony on the disparities in rural care, most specifically on the issue of allowable costs for Critical Access Hospitals (CAHs).

CAHs play an integral role in most States serving the health care needs of rural communities – delivering inpatient and outpatient services, as well as 24-hour emergency care. CAHs make it possible for individuals living with complex medical needs to remain in their communities without travelling long distances to receive the care they require. Currently, CAHs are reimbursed for 101% of reasonable costs to ensure they are able to maintain high quality care in communities with low patient volume and high proportions of Medicare and Medicaid patients. However, as we will describe in detail below, most in fact receive anywhere from 75 to 95 percent of the costs associated with Medicare and Medicaid Patients.

One of the challenges our members consistently face is the lack of continuity in how allowable costs are interpreted by Medicare Audit Contractors (MACs). The lack of clarity is particularly burdensome for systems that have CAHs located in different regions, and thus reviewed by different MACs, or when a new MAC begins reviewing the CAH. Currently, regulations are interpreted differently in each region with regards to allowable cost for CAHs – what may be allowed in one area is not allowed in another. Additionally, when a new MAC takes over a region, CAHs may suddenly be informed that a cost that was covered for years will not be moving forward. A uniform, nation-wide definition of allowable costs is needed to create consistency across the country.

Our members have identified several examples of the most common discrepancies they encounter:

> ***Emergency Room Physician Availability Cost:*** Some auditors have disallowed emergency room physician availability costs over a disagreement with the submitted time study methodology or an absence of a written allocation agreement. In addition, certain MACs do not follow Provider Reimbursement Manual guidance to calculate allowable costs.
>
> ***Certified Registered Nurse Anesthetist:*** Several CAHs have recently experienced certain auditors disallowing CRNA standby time, while different auditors always

allowed the expense. This is a huge expense for CAHs, and the limit may result in an end of OB coverage for districts, which are often an hour from another hospital.

Provider Fees/Taxes: For years, Provider taxes have been imposed by states on health care services such as a tax on inpatient hospital services or nursing facility beds. CMS has given MACs the authority to evaluate each state's provider taxes on an individual basis to determine if they are allowable. In recent years, some MACs determined that either all or part of this reimbursement is not allowed, this has resulted in several CAHs receiving notices that the recent audit has found that they were overpaid for this cost, in some cases very large sums from up to six years prior.

Thank you for providing us with the opportunity to express our concerns with the Ways and Means Committee. We are committed to the communities we serve, and we hope to continue this discussion with you and your staff to ensure that CAHs are able to maintain their services and guarantee high quality care to beneficiaries living in rural communities.

The Honorable Kevin Brady
Chair
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Representatives
Washington, DC 20515

The Honorable Jim McDermott, MD
Ranking Member
Subcommittee on Health
Committee on Ways and Means
United States House of
Washington, DC 20515

August 5, 2015

Statement for the hearing record: Hearing with the Medicare Payment Advisory Commission to discuss hospital payment issues, rural health issues, and beneficiary access to care

Submitted electronically to: waysandmeans.submissions@mail.house.gov

Dear Chairman Brady and Rep. McDermott:

On behalf of America's Essential Hospitals and its more than 250 member hospitals and health systems, I thank you for the opportunity to provide our thoughts regarding the July 22, 2015, hearing on Medicare hospital payment issues. Our member hospital systems are united by a commitment to serve all patients, including the most vulnerable, with the best health care possible. Essential hospitals are also primary providers of essential community services that touch all people, including trauma and burn care, disaster response, public health, preventive services, and medical education.

Our comments are on four specific areas: Medicare disproportionate share hospital (DSH) payments, the Hospital Readmissions Reduction Program (HRRP), Medicare indirect medical education (IME) payments, and issues related to Medicare payment for short inpatient stays.

essentialhospitals.org

AMERICA'S ESSENTIAL HOSPITALS
1901 Pennsylvania Ave NW Ste 950
Washington DC 20004

T 202.585.0000
F 202.585.0001
e info@essentialhospitals.org

Medicare DSH

To maintain their financial stability, members of America's Essential Hospitals rely on a patchwork of federal, state, and local support, including Medicare DSH payments. **Because our hospitals on average operate at a loss—an average negative 3.2 percent operating margin in 2013—scaling back any component of that support severely challenges essential hospitals' ability to serve their communities.**
Section 3133 of the Affordable Care Act (ACA) cut Medicare DSH funding by $22 billion from fiscal years 2014 to 2019. While DSH hospitals continue to receive 25 percent of their Medicare DSH payments as a per-discharge adjustment, the remaining 75 percent is decreased to reflect the change in the national uninsurance rate and distributed based on uncompensated care burden. This change was intended to better incorporate uncompensated care into the Medicare DSH formula to better target support at hospitals with the greatest need. America's Essential Hospitals has long supported this approach and continues to work with the Centers for Medicare & Medicaid Services (CMS) to ensure the targeting is conducted in a fair and accurate manner.

But we are concerned about the sustainability of continued reductions to the aggregate uncompensated care–based DSH payments that are occurring as coverage continues to expand and the national uninsurance rate falls. We urge the committee to evaluate the appropriateness of continuing these Medicare DSH cuts in light of the following points.

The aggregate amount of uncompensated care payments CMS has proposed for fiscal year (FY) 2016—$6.4 billion—incorporates a nearly 30 percent reduction from FY 2013 levels. This amount will continue to decline with the national uninsurance rate. Hospitals in states that have not expanded Medicaid are not experiencing the drop in uncompensated care that hospitals in expansion states have seen. The cuts have even challenged essential hospitals in expansion states because of continuing high levels of uncompensated care and the vulnerable people they serve.

Further, the CMS's current Medicare DSH methodology relies on an imprecise measure of hospital uncompensated care. Under the methodology, CMS determines a hospital's qualifying uncompensated care burden by estimating the hospital's percentage of the total uncompensated care costs incurred by all DSH hospitals. To date, CMS has concluded that due to shortcomings of the Medicare cost report S-10 worksheet, it must deviate from the common definition of uncompensated care and instead use a proxy to estimate hospital

uncompensated care costs. CMS notes the proxy is an interim measure and proposes to continue to monitor alternative proxies and data sources.

Given the substantial negative impact of the Medicare DSH cuts on essential hospitals—in both expansion and non-expansion states—and the shortcomings in data needed to accurately calculate uncompensated care, America's Essential Hospitals would support thoughtfully crafted legislation to stop further aggregate cuts to Medicare DSH. Since the hearing on July 22, Rep. Kenny Marchant introduced legislation changing the ACA's Medicare DSH cut policy by directing new funding to hospitals in states that have not expanded Medicaid under the Affordable Care Act. America's Essential Hospitals is currently analyzing the impact of this legislation and will provide feedback to the committee at a future time.

Medicare HRRP

Section 3025 of the ACA mandated the creation of the Medicare HRRP. The program was designed to give hospitals a financial incentive to reduce avoidable readmissions. While we agree with the general intent of the program, the current readmissions measures do not accurately reflect quality of care because they do not account for patients' complex social and economic circumstances that exist outside a hospital's control and drive readmissions. As the Medicare Payment Advisory Commission (MedPAC) noted in its written testimony: "Hospitals' readmission rates and penalties are positively correlated with their low-income patient share."

Because the HRRP fails to adjust for sociodemographic factors that lead to readmissions, many essential hospitals will suffer penalties unrelated to the actual quality of the care they provide. This reduction in funding will create a vicious cycle, making it even more difficult for hospitals to help patients overcome disadvantages and, in turn, further increasing readmissions. As noted above, most essential hospitals operate on narrow or negative margins and cannot absorb additional funding cuts. HRRP penalties could force some hospitals to make difficult decisions regarding the services they provide, the people they employ, and their reinvestments in the community.

America's Essential Hospitals supports legislation drafted by Rep. Jim Renacci: H.R. 1343, Establishing Beneficiary Equity in the Hospital Readmission Program Act. H.R. 1343 would mitigate the unequal treatment of hospitals in a two-stage approach. First, for fiscal years 2016 and 2017, the bill would require CMS to make a risk adjustment that accounts for both a hospital's

proportion of inpatients who are full-benefit, dually eligible individuals; and the socioeconomic status of the patients a hospital serves. Second, for fiscal years after 2017, the bill would require CMS to risk adjust the readmission measures based on findings from the Improving Medicare Post-Acute Care Transformation Act of 2014, and also require MedPAC to report on the appropriateness of the program's 30-day threshold for readmissions. America's Essential Hospitals remains open to solutions other those in H.R. 1343 to limit the negative impact HRRP has on essential hospitals and their vulnerable patients.

Medicare IME

Members of America's Essential Hospitals commit to training the nation's future health care workforce. **In fiscal year 2013, our more than 250 member hospitals trained, on average, 254 physicians per hospital, which is 14 times as many as the average number trained at other U.S. teaching hospitals.**

Graduate medical education (GME) payments cover the direct cost of physician training. Medicare IME payments are designed to cover the indirect higher costs of operating a teaching hospital. The Balanced Budget Act of 1997 capped the number of residency slots for which Medicare can reimburse teaching hospitals. **These caps, based on training levels when Congress passed the 1997 law, are long outdated and have not increased with training needs. Nevertheless, to further their missions and despite financial stress, many essential hospitals train above their Medicare caps.** The funding shortfall for each resident trained beyond a hospital's cap creates additional financial strain on essential hospitals.

America's Essential Hospitals would support legislation to remedy the ongoing problem presented by an inadequate number of physician residency slots funded by GME, particularly for public and nonprofit teaching hospitals. Since the hearing on July 22, Chairman Brady introduced legislation that would substantially change the formula by which Medicare distributes funds for IME. America's Essential Hospitals is analyzing the legislation and looks forward to discussing this important issue further with the committee.

Medicare Short Stay Policy

In its FY 2014 inpatient prospective payment rule, CMS first announced the "two-midnight" policy. But in response to concerns raised by providers and

Congress, the agency put in place am enforcement ban on parts of the regulation and has repeatedly extended the ban. Most recently, CMS extended the ban until September 30, 2015, based on a requirement in the Medicare and CHIP Reauthorization Act of 2015. **The repeated extension of the enforcement ban indicates that the agency, hospitals, and other stakeholders are not prepared to implement the two-midnight policy. America's Essential Hospitals supports further extending this ban until appropriate changes to the two-midnight policy are enacted.**

In CMS' Outpatient Prospective Payment System proposed rule, the agency responded to stakeholders' concerns about the impact of the policy on clinicians' judgment by proposing to revise its short stay policy. This proposal would allow for Medicare reimbursement for short inpatient stays in cases where the admitting physician believes the inpatient admission is medically necessary. **We believe that this is a step in the right direction, as ultimately only a physician can decide which setting of care is most appropriate for a patient. This proposed change, in conjunction with measures to limit RACs' ability to overturn admission decisions made by physicians, are important steps in addressing concerns about the impact of the policy on hospitals and their ability to provide an appropriate level of care to patients.**

Since the hearing, Chairman Brady introduced the "Medicare Crosswalk Hospital Code Development Act." America's Essential Hospitals is analyzing the legislation and looks forward to providing feedback to the committee.

Thank you again for the opportunity to comment on these important payment policies. We look forward to providing more feedback regarding recently introduced legislation in several of these areas.

Sincerely,

/s/

Bruce Siegel, MD, MPH
President and CEO

August 6, 2015

Congressman Kevin Brady
Chairman
House Ways & Means Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

Congressman Jim McDermott
Ranking Member
House Ways & Means Subcommittee on Health
1106 Longworth House Office Building
Washington, DC 20515

RE: Statement for the Record of the Subcommittee Hearing on Rural Health Care Disparities Created by Medicare Regulation

Dear Chairman Brady and Ranking Member McDermott:

On behalf of the Kaweah Delta Health Care District, we are pleased to offer this statement for the record of your recent hearing. We believe our location, catchment area, and our newly Accreditation Council for Graduate Medical Education (ACGME) accredited GME program, provide us with a unique perspective on rural health.

As you may already be aware, Kaweah Delta is located in Visalia, California, in the heart of the largely rural and agricultural Central Valley. We serve a population of over half a million people that spans 41 zip codes surrounding our main hospital campus. Although our main campus is located within the city limits of Visalia, over fifty percent of the population we serve resides in rural areas of Tulare County. As a result, our medical team focuses on a unique group of both rural and urban patient needs at all times of the year. We are currently designated as a Level 3 trauma center and are evaluating a move to upgrade our trauma capabilities to an ACS Level 2 trauma center, which will bring many additional patients from around the Central Valley region of California.

While our GME program is just beginning, we have made several observations during our implementation that we would like to bring to the Committee's attention. Since our accreditation in 2011, we have established a Family Medicine program, an Emergency Medicine program, and a Psychiatry Residency program. We are also beginning our first class for the Transitional Year program and our General Surgery program.

Below you will find our observations on rural health and GME. If you would like additional clarification or comment on any of these responses, please contact me at (559) 624-2330 or lmann@kdhcd.org. You may also contact Lynn Jacquez who is our representative in Washington, D.C. at (202) 465-3000 or ljacquez@cj-lake.com.

Sincerely,

Edward Hirsch, MD
VP, Chief Medical Officer

1) **The U.S. has an abundance of medical school graduates but not enough residency positions.**

   Because 50% of residency graduates (who are usually in the time of their lives to get married, have children and settle down) stay within 50 miles of where they completed their residency training, it is important to locate the training where the patients need them.

2) **Rural medicine should be synonymous with a wider scope of practice. In essence, it is the opposite of a specialist.**

   What is considered a specialist's procedure in Chicago (ie vasectomy) is well within the scope of a primary care physician in Visalia, California. The current model, designed around tertiary care training, breeds this narrower subspecialist mentality and reduces access to care. One does not need a urologist to perform a vasectomy but one will if the Family Medicine physician is not properly trained. Family Medicine as a specialty gets weaker because of this movement of specialized training in tertiary care centers.

3) **In order to achieve any semblance of adequate reimbursement for patient services, Kaweah essentially must partner with the local Federally Qualified Health Center (FQHC).**

   The clinic is located next to the hospital and although the catchment area of the hospital is rural, the zipcode of the clinic is not. There is a new Health Resources and Services Administration (HRSA) waiver process that would allow for reimbursement through the FQHC that we think may help. However, pairing with a local FQHC does not always achieve the same goals and objectives or ACGME requirements as the residency program and is a contractual nightmare and an issue with which institutions across the country struggle.

4) **There are few federal resources available for developing a new GME program. Most grants have statutes stipulating prior ACGME accreditation is already awarded.**

   The current system forces institutions like ours to incur significant startup costs for programs. Kaweah believes that the current system tends to benefit existing GME programs at the expense of new ones. Therefore, we would support the creation of a GME transformation fund that would be specifically dedicated to developing and evaluating innovative GME programs.

5) **The existence of Kaweah's GME program has already helped the hospital to recruit and retain highly vested, systems-based focused physicians.**

These physicians practice here because they want to train residents. Doctors that would otherwise wish to practice in other areas of the Country where reimbursement rates are higher, are attracted to the opportunity to teach residents. As a result, access to care is improved even before one resident graduates from a program. However, it is well known that physicians who train residents at academic centers do not get reimbursed as well as those who work in the private sector. This lower reimbursement, coupled with Kaweah's additional rural status recruitment challenge essentially mandates stronger financial support of the education efforts of physicians than the tertiary care centers in order to keep reimbursement within fair market value and to meet the health care needs of our patients.

6) **Kaweah is fortunate to control a few rural health clinics (RHCs) in the area. In our efforts to build GME and potentially begin internal medicine, neurology and OB/Gyn residency programs, we will need to recruit many specialists to the area (ie – endocrinology, gynecology/oncology).**

These subspecialties are highly needed for our patient population. It would be doubly beneficial if we could add these specialists, who will work clinically with residents at the RHCs, to the hospital's call panel to provide access to care in the specialty. In making this change, a hospital could maximally support the specialists required for creating a residency program in the RHC while adding to the call coverage capabilities of the institution. We are aware that RHC services must be primarily primary care. It would be beneficial to create programs that support the location of specialists in the RHCs and to reward the coordination of the delivery of specialty care with the local FQHC rather than foster competition between the RHCs and the FQHC over primary care.

In order to satisfy their specialty needs, the FQHC is then forced to scrounge (often times unsuccessfully) for sparsely available specialty referrals in faraway locations (Bakersfield and Fresno) rather than in their own backyard at Kaweah. Eventually the patient who never gets the referral, or who needs to wait months and months for the referral, becomes so ill that they visit our Emergency Department because they had nowhere else to turn.

Written Testimony of

Steve R. Ommen, MD
Medical Director, Mayo Clinic Center for Connected Care

How to Improve Rural Health Care Disparities through Changes in Federal Telehealth Policy

Submitted to:
House Ways and Means Subcommittee on Health
Hearing on Rural Health Care Disparities Created by Medicare Regulations

The Honorable Kevin Brady, Chairman
The Honorable Jim McDermott, Ranking Member

July 28, 2015

Mayo Clinic Contacts:

Kathleen Harrington
Chair, Division of Government Relations
200 First Street, SW
Rochester, MN 55905
(507) 266-4812
(507) 538-4583 (fax)
harrington.kathleen2@mayo.edu

Jennifer Mallard
Director, Federal Government Relations
1455 Pennsylvania Ave., NW, Suite 400
Washington, DC 20004
(202) 327-5424
(507) 538-4583 (fax)
mallard.jennifer@mayo.edu

Thank you for the opportunity to share our recommendations with respect to improving rural health care disparities created by Medicare regulations. While there are many issues impacting rural health care disparities, I am writing to specifically address how the advancement of telehealth through changes in federal policy can expand the reach of medicine and knowledge, save health care costs and, most importantly, improve outcomes and reduce health disparities for patients located in rural communities.

As part of the largest integrated, not-for-profit medical group practice in the world, Mayo Clinic physicians see great potential to improve health and health outcomes for people in rural communities through greater use of telehealth services. In addition, because our physicians see patients from all 50 states each year, Mayo is acutely aware of the barriers that exist at both the federal and state levels that inhibit the delivery of medical services through "connected care," our term for the spectrum of telehealth platforms. Indeed, I write in my capacity as the Medical

Director of Mayo Clinic's Center for Connected Care. Mayo uses connected care in many aspects of our practice from saving lives with our telestroke program, to enabling video consultations in skilled nursing facilities, to monitoring intensive care patients at rural facilities and across state borders, to sharing our knowledge with physicians across the country through eConsults and our AskMayoExpert program. In all of these situations, we have observed that connected care improves access, service and affordability for our patients.

Below are five policy priorities that will help advance the delivery of telehealth and work to reduce health disparities in all parts of the country, and most critically in our rural communities.

1. Promote telehealth delivery to improve access to critical care in rural areas

Mayo's initiative in telestroke diagnosis has shown great promise in improving patient outcomes and reducing health care costs. Researchers have found that using telehealth to deliver stroke care, also known as telestroke, not only improves patient outcomes, but is cost-effective for health care payers.

In telestroke care, the use of a secure, high definition telestroke monitor allows a patient presenting with symptoms of a stroke to be examined in real time by a neurology specialist from a remote location. The neurologist consults via computer with the emergency room physician at the patient's site, which like most rural hospitals, may not have neurology specialists. Mayo provides telestroke care by acting as a single source of specialized care – a hub – to connect a network of multiple hospitals – spokes. Many of these "spokes" are Critical Access Hospital sites that do not have the patient volumes or the financial resources to offer 24-hour access to specialized critical care.

A Mayo study estimated that compared with no network, a modeled telestroke system consisting of a single hub and seven spoke hospitals may result in the appropriate use of more clot-busting drugs, more catheter-based interventional procedures and other stroke therapies, with more stroke patients discharged home independently. Despite upfront and maintenance expenses, the entire network of hospitals realizes a greater total cost savings.

When comparing a rurally located patient receiving routine stroke care at a community hospital, a patient treated in the context of a telestroke network incurred $1,436 fewer costs. The improvement in outcomes is associated with reduced resource use (such as inpatient rehabilitation, nursing homes, and caregiver time). Mayo Clinic Telestroke maintains hubs in Arizona, Florida, and Minnesota, and serves more than 20 health care institutions in seven states. We estimate that in Arizona alone telestroke services have saved more than 70 quality years of human life and $5 million societal dollars since 2008. The Mayo study showed that expansion of telestroke networks across the country can improve patient-related outcomes and quality while saving overall costs, including Medicare and Medicaid funds.

Enhanced critical care remote monitoring is another example of an innovative delivery system that would improve outcomes and save health care costs if diffused more broadly. To illustrate, ICU (intensive care unit) patients in Eau Claire and La Crosse, Wisconsin, are monitored 24 hours a day, seven days a week by critical care specialists located in Rochester, Minnesota, utilizing Mayo connected care systems. Through constant surveillance, and by providing the care

teams with timely patient information, E-ICUs have been associated with a 55 percent reduction in ICU mortality and a 40 percent reduction in clinical complications.

We encourage Congress to direct the Centers for Medicare & Medicaid Services (CMS) to take advantage of this innovative care delivery by exploring alternative payment methods to more widely expand adoption of these uses of telehealth. We would be happy to provide greater detail on both the telestroke and E-ICU initiatives to the committee.

2. Lift geographic and originating site restrictions

The advantages of connected care services are not only applicable when the patient is distant or in a very remote location, but also because they can be in touch more often with more appropriate, logistically simpler methodologies than the traditional face-to-face encounter. The CMS requirement that telehealth consults be confined to authorized originating sites, such as hospitals and clinics, prevents home bound residents from receiving quality home monitoring. While travel time and distance can be important factors, there are many patients in both urban and rural settings whose limited mobility makes it equally problematic to travel from home to a clinic. A patient may live in a rural area; however, the closest originating site may be in the hospital located in the nearest small city with a population of 50,000, making the visit ineligible for telehealth coverage. Medicare telehealth restrictions do not recognize the advances in technology, cost savings and patient demand for remote health care delivery –especially in our rural communities.

While CMS recently expanded coverage slightly to include rural census tracts within a Metropolitan Statistical Area (MSA), we encourage Congress to direct CMS to remove all geographic and originating site limitations, and follow the lead taken by most state Medicaid programs, which have lifted these arbitrary geographic and originating site restrictions enabling Medicare patients to receive connected care services regardless of location.

3. Expand coverage for store-and-forward or asynchronous communications

The use of secure, asynchronous (also referred to as store-and-forward) exchange of medical information effectively and economically uses telehealth technology to improve patient access and quality of care. In our outpatient clinic settings, we use this technology with our eConsults program, both within the Mayo system and with outside health organizations. This enables compliant provider-to-provider exchange of clinical information to allow subspecialty consultations to help guide diagnosis and management of more complex cases through a review of the patient's medical record, imaging studies and laboratory tests without the patient having to schedule an appointment time or go to a specific location. This saves time and the cost of scheduling visits, and improves access for other patients that require face-to-face encounters by freeing up capacity where a face-to-face visit was not warranted. Additionally, for some patients, this maximizes the care they can receive in their rural primary health care market and increases patient access to expert consultation that otherwise may be foregone if they were unable to afford additional time away or experience travel barriers to more distant facilities. Not only does this help alleviate the physician shortage in rural areas, it also saves the regional providers the costs and salary of hiring dedicated sub-specialists.

4. Expand coverage for patient home monitoring

A recent Mayo randomized study, published in *Telemedicine and E-Health*, of more than 200 patients who received either additional home telehealth monitoring or the usual medical care, found that those receiving care via telemedicine had less variability in cost of care, lower decedents-to-survivors cost ratio, and lower total 30-day readmission cost than patients receiving traditional medical care.[1]

5. Collaborate through medical licensure compacts

The patchwork of state-by-state medical licensing rules presents a costly and time-consuming administrative barrier to connected care services expansion both within health systems that span state lines, as well as with providers in other health systems. Presently, in order to provide medical advice via telehealth services, providers must be licensed in the state where the patient resides. While a national licensure system has been part of the widespread policy debate, the adoption of the state-by-state Medical Licensure Compact (currently adopted by 11 states) promises to be a significant improvement. In rural communities on or near state borders, a provider in a neighboring state may be more proximate to a patient than the nearest provider of the same type in their home state.

Conclusion

As advances in technology and consumer demand for telehealth options grow, government policies must keep pace with these technological and societal changes. This is important because we have seen firsthand at Mayo Clinic that telehealth provides great benefits, including greater convenience for patients and their families, safer care, better outcomes, fewer redundancies, and ultimately higher quality and cost savings for patients, providers and payers, including the Medicare and Medicaid programs. Moreover, government policies should ensure patient access to telehealth by encouraging physician-to-physician consultations and physician-to-patient services that are integrated into various care settings (clinics, hospitals, nursing homes, home health agencies, etc.). A patient's health care needs are not defined by where they live or where they receive health care; thus, telehealth solutions enable patients and providers access to clinical expertise and care alongside the local and regional health care organization, offering wider sub-specialty care, convenience and fewer costs for the patient and his/her family. In the end, Mayo Clinic believes this will help address some of our disparities in the provision of health care services.

Thank you for the opportunity to address how advancing telehealth services through changes in federal health policy can improve health care disparities in our rural communities. If you have any additional questions or would like to have more information, please reach out to Kathleen Harrington at 507-266-4812 or harrington.kathleen2@mayo.edu or Jennifer Mallard at 202-621-1850 or mallard.jennifer@mayo.edu.

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[1] Upatising Benjavan, Wood Douglas L., Kremers Walter K., Christ Sharon L., Yih Yuehwern, Hanson Gregory J., and Takahashi Paul Y., Telemedicine and e-Health. January 2015, 21(1): 3-8. Doi:10.1089/tmj.2014.0021.

Statement

Of

The National Association of Chain Drug Stores

For

United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

Hearing on:
Rural Health Care Disparities Created by
Medicare Regulations

July 28, 2015
10:00 A.M.

1100 Longworth House Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
Arlington, VA 22209
703-549-3001
www.nacds.org

The National Association of Chain Drug Stores (NACDS) thanks Chairman Brady and the members of the Subcommittee on Health for the opportunity to submit the following statement for the record regarding rural health care disparities created by Medicare regulations. NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other health care providers to improve the quality and affordability of health care services.

NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS' chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 179,000 pharmacists. They fill over 2.9 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and health care affordability. NACDS members also include more than 850 supplier partners and over 60 international members representing 22 countries. For more information, visit www.NACDS.org.

The national physician shortage coupled with the continued expansion of health insurance coverage will have serious implications for the nation's health care system. Access, quality, cost, and efficiency in health care are all critical factors – especially to the medically underserved and those living in rural areas. Currently, the Medicare statute does not recognize pharmacists as a provider in the Medicare program. By recognizing and utilizing pharmacists, Medicare can fill the health care gaps currently experienced in the rural setting and help ensure access to requisite health care services for this vulnerable population.

As the face of neighborhood health care, community pharmacies and pharmacists provide access to prescription medications and over-the-counter products, as well as cost-effective health services such as immunizations and disease screenings. Retail pharmacies are often the most readily accessible health care provider. Nearly all Americans (94%) live within five miles of a community retail pharmacy. Recognition of pharmacists as providers under Medicare Part B would help to provide valuable and convenient pharmacist services to millions of Americans, and most importantly, to those who are already medically underserved or reside in rural areas. Access to these types of services is especially vital for Medicare beneficiaries as nearly two-thirds are suffering from multiple chronic conditions. Through personal interactions with patients, face-to-face consultations and convenient access to preventive care services, local pharmacists are helping to shape the health care delivery system of tomorrow—in partnership with doctors, nurses, and others.

Retail community pharmacists provide high quality, cost efficient care and services. However, the lack of pharmacist recognition as a provider in Medicare has limited the number and types of services pharmacists can provide, even though fully qualified to do so. For this reason, we support H.R. 592, the "Pharmacy and Medically Underserved Areas Enhancement Act," which would allow Medicare Part B to utilize pharmacists to their full capability by providing medically-underserved beneficiaries with services not currently reaching them (subject to state scope of practice laws).

The medically-underserved population includes seniors with cultural or linguistic access barriers, residents of public housing, persons with HIV/AIDS, as well as rural populations and many others. Significant consideration should be given to innovative initiatives within

the medically-underserved population to enhance health care capacity and strengthen community partnerships to offset provider shortages and the surge in individuals with health care coverage. It is especially important that underserved beneficiaries have continued access to a provider for follow up and to ask questions; oftentimes this is the community pharmacist. NACDS urges the adoption of policies and legislation that increase access to much-needed services for underserved Americans, such as H.R. 592. This important legislation would lead not only to reduced overall health care costs, but also to increased access to health care services and improved health care quality for underserved patients, including those living in a rural setting.

Conclusion

NACDS thanks the subcommittee for consideration of our comments. We look forward to working with policymakers and stakeholders on looking to find ways to improve care for Medicare patients who are underserved or live in rural areas.

Contact: Maggie Elehwany
Vice President
Government Affairs and Policy
National Rural Health Association

Elehwany@nrharural.org
(202) 639-0550
1025 Vermont St. NW, Suite 1100
Washington, DC 20005

Testimony of the National Rural Health Association (NRHA)
Concerning Access to Rural Health Care
Submitted for the Record to the House Committee on Ways and Means
Subcommittee on Health – July 28, 2015

The National Rural Health Association (NRHA) is pleased to provide the House Ways and Means Subcommittee on Health a statement regarding the significance of rural health care to patients and providers.

NRHA is a national nonprofit membership organization with a diverse collection of 21,000 individuals and organizations who share a common interest in rural health. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research.

Access to quality, affordable health care is essential for the 62 million Americans living in rural and remote communities. Rural Americans are more likely to be older, sicker and poorer then their urban counterparts. Specifically, they are more likely to suffer with a chronic disease that requires monitoring and follow up care, making convenient, local access to care necessary to ensuring patient compliance with the services that are necessary to reduce the overall cost of care and improve the patients' outcomes and quality of life. Yet, many rural Americans live in areas with limited health care resources, restricting their available options for care, including primary care.

Rural Medicare beneficiaries face a number of challenges when trying to access health care close to home. Seventy-seven percent of rural counties in the U.S. are Primary Care Health Professional Shortage Areas while nine percent have no physicians at all. Rural seniors are forced to travel significant distances for care, especially specialty services. In an emergency, rural American travel twice as far as their urban counterparts to receive care. As a result, while 20 percent of Americans live in rural areas, 60 percent of trauma deaths occur in rural America.

Rural programs and designations, from the Physician Work Geographic Practice Cost Index to Critical Access Hospitals, are essential to increasing the capacity of the rural health care delivery system to ensure access for rural senior and make sure these rural safety net providers can fulfill that mission. NRHA urges the Committee to continue its strong support of these important programs.

Rural Payment Provider Policies

Congress has created several rural health payment provisions to improve access to care in rural America. While these programs have been largely successful in maintaining access, continuation of these payments and rural health extenders is crucial. To provide these rural providers with certainty and the ability to engage in longer term planning, NRHA has long sought legislation to make the rural extenders permanent. But even with the existing program, the problem of access still remains. Rural Healthy People 2010 highlighted access as the greatest

challenge in rural health. Unfortunately, even with the existing rural health programs, it remains the number one problem in the updated Rural Health People 2020. More must be done to ensure rural Americans have access to the health care resources necessary to allow them to lead healthy lives.

Rural health care delivery is challenging. Workforce shortages, older and poorer patient populations, geographic barriers, low patient volumes and high uninsured and under-insured populations are just a few of the barriers. Rural physicians and hospitals work around many of these barriers to provide high quality personalized care to their communities. Congress has address some of the payment related barriers by creating specific payment structures for certain rural providers to better address the unique patient populations and structural challenges faced by these small rural practices.

Medicare and Medicaid – major components of rural health care – pay rural providers less than their urban counterparts. Medicare spends 2.5 percent less on rural beneficiaries than it does on urban beneficiaries. Rural health care providers operate on very thin margins and many rural communities have severe medical workforce shortages. Yet, rural physicians, who put as much time, skill and intensity into their work as their urban counterparts, are reimbursed at lower rates.

These congressionally established rural payment programs for hospitals and providers are not 'bonus' or 'special' payments, but rather alternative, cost-effective and targeted payment formulas that maintain access to care for millions of rural patients and financial stability for thousands of rural providers across the country. Without these programs, rural patients would be forced to travel further for more expensive care. Or worse, these rural Americans would forego essential care because they could not reach the necessary medical providers, resulting in poorer health, a lower quality of life, and more expensive care later. The existing rural payments help, but rural access remains a critical problem with potential life and death consequences for rural Americans.

Hospital Closure Crisis

Rural health care challenges are well known – from accessing health care services to recruiting and retaining health professionals. Rural communities depend on safety net providers such as Critical Access Hospitals, Community Health Centers, Rural Health Clinics and Federally Qualified Health Centers.

But these important rural access points are facing a closure crisis. Fifty-five rural hospitals have closed since 2010; 283 more are on the brink of closure. Since the start of 2013, more rural hospitals have closed than in the previous 10 years—combined. These closures are a part of a larger trend according to the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, and their numbers show the rate is escalating. Continued cuts in hospital reimbursements have taken their toll, forcing far too many closures and leaving many of our nation's most vulnerable populations without timely access to care.

If Congress allows these 283 rural hospitals on the brink to close, then 700,000 patients

would lose direct access to care. Already 640 counties across the country are without quick access to an acute-care hospital. Seventy-seven percent of the nation's 2,041 rural counties are Health Professional Shortage Areas. More than 40 percent of rural patients have to travel 20 or more miles to receive specialty care, compared to 3 percent of metropolitan patients.

A rural hospital closing doesn't just hurt patients; it hurts the rural economy as well. In rural America, the hospital is often one of the largest employers in the community. Health care in rural areas can represent up to 20 percent of the community's employment and income. The average CAH creates 195 jobs and generates $8.4 million in payroll annually. If a rural provider is forced to close their door the community erodes. If we allow the 283 rural hospitals that are on the brink to close: 36,000 direct rural health care jobs will be lost; 50,000 rural community jobs will be lost; and rural economies would take a $10.6 billion loss. When a rural hospital closes, leaving a community without local access to health care, the community quickly begins to die.

From 1990 to 1999, 208 rural hospitals closed and rural Americans lost access to health care. These hospitals struggled to maintain financial stability under the urban-centric Medicare Prospective Payment System because of their small size and unpredictable patient mix. Congress enacted the Medicare Rural Hospital Flexibility Program as part of the Balance Budget Act (BBA) of 1997, creating the Critical Access Hospital (CAH) designation. This designation was designed to prevent hospital closures by allowing CMS payments to more accurately reflect the realities of providing care in rural America. The CAH payment structure allows for more flexible staffing options relative to community need, simplifying billing procedures and creating incentives to develop local integrated health delivery systems, including acute, primary, emergency and long-term care.

Congress created unique payment structures for certain rural providers to enable them to keep their doors open and to allow them to continue to serve their communities by providing access to high quality health care.

Rural Hospitals provide cost-effective primary care. It is 2.5 percent less expensive to provide identical Medicare services in a rural setting than in an urban or suburban setting. This focus on primary care, as opposed to specialty care, saves Medicare $1.5 billion per year. Quality performance measurements in rural areas are on par if not superior to urban facilities.

NRHA asks members of the Committee to consider the impact of access to care for rural Americans when necessary safety net providers close. Fifty five rural hospitals have already closed, and 283 are on the brink of closure. NRHA is calling on members of Congress to stabilize the rural hospital closures. Rural health care delivery is challenging. Workforce shortages, older and poorer patient populations, geographic barriers, low patient volumes and high uninsured and under-insured populations are just a few of the barriers. NRHA understands the need for an innovation model for rural hospitals who continue to struggle, while ensuring access to emergency care and outpatient care that meets the needs of their unique rural communities.

Regulatory Relief Needed

NRHA calls on regulatory relief to help the Medicare beneficiaries in rural America. The elimination of the CAH 96 Hour Condition of Payment, the rebase of supervision requirements for outpatient therapy services at CAHs and rural PPS facilities, and modification to the 2-Midnight Rule and RAC audit and appeals process would help relieve burdens placed unfairly on these small, rural hospitals and providers.

NRHA calls for the elimination of the 96 hour Condition of Payment requirement that physicians at CAHs certify, at the time of admission that a Medicare patient will not be at the facility for more than 96 hours. From the creation of the CAH designation until late 2013 an annual average of 96 hour stays allowed CAHs flexibility within the regulatory framework set up for the designation. The new policy of strict enforcement of a per stay 96 hour cap creates unnecessary red-tape and barriers for CAHs throughout rural America; and eliminates important flexibility to allow general surgical services well suited for these high quality local providers.

The 96-hour rule is counter to the clear congressional intent to provide CAHs greater flexibility, evident in the 1999 modification of the 96 hour condition of participation from a hard 96 hour cap to a flexible annual average. The sudden imposition of the condition of payment is unnecessary and limits access to health care in rural areas and disallows rural providers to focus on caring for their patients. This regulation interferes with the best judgment of physicians and other health care providers, placing them in a position where high quality and qualified local providers cannot provide care for their patients. As a result, patients have had to seek care far from home. Additionally, since it is 2.5 percent less expensive to provide identical Medicare services in a rural setting than in an urban or suburban setting, such a transfer results in greater Medicare expenditures. Removing the 96-hour rule condition of payment would allow for rural patients to receive the care they need in their local communities.

The solution is legislation

Twenty percent of Americans live on the 90 percent of America that is rural. For these Americans local access to care is essential, but there are substantial barriers and challenges involved in providing this care. The rural payment programs created by Congress address just some of these challenges and help protect the rural health care safety net and provide critical access to health care for rural Americans. Rural physicians and hospitals generate billions of dollars for the local economy. Studies at the National Center for Rural Health Works at Oklahoma State University have found that one full-time rural primary care physician generates about $1.5 million in revenue, and creates or helps create 23 jobs. Rural health care systems make huge economic contributions to their communities. Reducing rates for rural providers will force many facilities to offer reduced services or even close their doors, further reducing access to care for rural Americans and transferring patients to more expensive urban providers. Rural hospital closures also devastate local economies. In the past, a closed hospital has meant as much as a 20 percent loss of revenue in the local rural economy, 4 percent per capita drop in income, and a 2 percent increase in the local unemployment rate.

Medicare payment policies are critical to the ability of our rural health care safety net and the ability for our health care providers to continue to provide quality care to rural Americans.

The development of permanent policies that address these issues is vital to the ongoing success and viability of the rural health care safety net.

In the past, members of Congress have looked towards bipartisan rural legislation to address issues in the long-term and provide rural providers with the certainty they need. We encourage the committee to look at the Save Rural Hospitals Act, introduced by Reps. Sam Graves (R-MO) and Dave Loebsack (D-IA) as a guide for addressing all these issues in the long-term.

The National Rural Health Association appreciates the opportunity to provide our recommendations to the Subcommittee. These programs are critical to the rural health delivery system and help maintain access to high quality care in rural communities. We greatly appreciate the support of the Subcommittee and look forward to working with Members of the Subcommittee to continue making these important investments in rural health.

Statement of the Rural Hospital Coalition

House Committee on Ways and Means
Subcommittee on Health

"Rural Health Care"

July 28, 2015

Submitted by Nancy Taylor
On Behalf of the Rural Hospital Coalition
202.331.3133

Statement of the Rural Hospital Coalition

House Committee on Ways and Means
Subcommittee on Health

"Rural Health Care"

July 28, 2015

"Rural hospitals face huge challenges; nearly 50 of them have closed in the last four years, according to the North Carolina Rural Health Research Program. But the many successful hospitals, beyond providing an array of jobs from the bottom to the top of the economic ladder, also stimulate local spending and help attract new businesses that offer a stable of insured patients."

– ***New York Times*, April 29, 2015**[1]

The Rural Hospital Coalition would like to thank Chairman Kevin Brady (R-TX), Ranking Member Jim McDermott (D-WA), and other Members of the Health Subcommittee for holding a hearing on Medicare issues associated with rural health care.

The Rural Hospital Coalition represents nearly one-fifth of all rural hospitals in America, with nearly 200 facilities located across more than thirty states. Our hospitals are major economic drivers in rural communities, providing jobs, economic development and the health care needed to keep rural Americans thriving. In many rural communities, hospitals serve as one of, if not *the*, largest employers. Rural hospitals can account for a full 20% of the economic activity that a rural community sees in a year. A rural hospital is often a vital element in attracting outside investment and new employers to a rural community.

Rural hospitals frequently serve as the sole provider of health care for their community. They care for individuals who, on average, earn significantly less than those in urban areas and are more likely to live at or below the Federal poverty level. Rural Americans are more likely to have comprised overall health[2] and are less likely to have private health insurance or prescription drug coverage. As a result, rural hospitals provide higher rates of uncompensated care than metropolitan facilities[3]. These hospitals also see a greater share of patients on Medicaid than urban facilities[4] – a program that has historically paid less for hospital services than the actual costs associated with providing care.[5] And while Medicare payments to rural hospitals are also

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[1] Searcey, Dionne. "Hospitals provide a pulse in struggling rural towns," New York Times, April 29, 2015.
[2] National Rural Health Association, What's Different about Rural Health Care?, http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care, Accessed December 26, 2013.
[3] Id.
[4] Rural Assistance Center, What are some challenges that rural hospitals face?, http://www.raconline.org/topics/hospitals/faqs, Accessed January 3, 2014.
[5] American Hospital Association, *Underpayment by Medicare and Medicaid: Fact Sheet*, December 2010, http://www.aha.org/content/00-10/10medunderpayment.pdf.

proportionally less than those paid to urban hospitals for the same services, Congress has initiated payment policies that help offset these and other challenges faced by rural hospitals – such as lower patient volumes and the recruitment and retention of physicians and other health care providers[6].

The rural payment policies created by Congress have been critical to the preservation of health care services to rural Americans. This is why the Rural Hospital Coalition applauds Congress for extending several Medicare payment programs in the recent Medicare Access and CHIP Reauthorization Act.[7] We especially thank Congress for extending the improved payment for low-volume hospitals and the Medicare Dependent Hospital ("MDH") programs through October 1, 2017.

Going forward, we urge Congress to strengthen these polices and make them permanent. Our hospitals need the certainty that comes with permanent Medicare payment supports. Together, the CBO estimates that these two programs will cost just $600 million per year in 2016 and 2017. This year, these programs will amount to approximately 0.04% of net Medicare outlays. But while their financial impact is miniscule relative to total Medicare spending, these policies provide a much-needed lifeline to rural hospitals and the communities they serve.

Improved Payment for Low-Volume Hospitals

The improved payment for low-volume hospitals applies a percentage add-on for each Medicare discharge from a hospital that is located 15 road miles or more from another hospital[8], and has less than 1,600 Medicare discharges during a fiscal year. This provision affords qualifying hospitals an enhanced payment to account for the higher incremental costs associated with a low volume of discharges, as compared to the lower incremental costs incurred per patient at higher volume hospitals. The enhanced payment is not provided after a one-time qualification, but requires that a hospital provide sufficient evidence to demonstrate that it continually meets the discharges and distance requirements, ensuring that hospitals which do not consistently qualify for the payment are not unjustly enriched by a one-time qualifying discharge rate or distance measurement.

Medicare Dependent Hospital Program

The MDH program dates back to 1987, and was "intended to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges."[9] Congress applied this designation to rural hospitals with 100 beds or fewer, not classified as an SCH, and having at least 60% of inpatient days or discharges covered by Medicare. As noted by the Medicare Payment Advisory Commission ("MedPAC"), a greater dependence on Medicare makes such hospitals more financially vulnerable to the prospective payment system ("PPS"). The MDH designation mitigates this financial risk, providing an enhanced payment to account for reduced payments under PPS. Additionally, the MDH designation provides small rural hospitals assurance that if its caseload falls by more than 5 percent due to circumstances beyond

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[6] Id.

[7] P.L. 114-10

[8] This applies only to "subsection (d) hospitals" - Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

[9] MedPAC, *Summary of Medicare's special payment provisions for rural providers and criteria for qualification*, June 2001, at 142.

its control, the MDH will receive such payments as necessary to cover fixed operating costs. This designation allows many rural hospitals to keep their doors open.

In addition to the two programs discussed above, the Rural Hospital Coalition also applauds Congress for extending ambulance add-on payments through January 1, 2018. Rural hospitals depend on ambulance providers, who must deal with the challenges posed by lower patient volumes and longer travel distances that are part of the nature of rural health care. Recognizing the increased costs faced by rural ambulance providers, Congress created an add-on for rural ambulance services in the Medicare Prescription Drug, Improvement, and Modernization Act. Today, the add-on amounts to 3 percent and helps ensure that rural Americans have access to emergency health services when needed.

Telemedicine

We urge Congress to support innovations that will permit greater use of telehealth in the vast rural and frontier areas we serve. The innovations occurring in the private marketplace should be permitted under Medicare. Medicare policies are limiting our ability to expand the use of these programs and urge Congress to pass legislation that permits physicians to use state-of-the-art technology to care and treat patients.

Conclusion

We hope that this testimony provides insight into the impact that these Medicare payment policies have on sustaining health care delivery in rural America. The attached chart outlines the five active Medicare payment policies that bolster rural hospitals, as well as the seven payment policies that have expired in recent years – a loss that is still felt by rural providers.

Thank you and we look forward to working with all Members on these important issues.

RURAL HOSPITAL COALITION

Medicare Payment Policies

As providers of health care in America's rural communities, we have a special understanding of the adverse impact failure to pass these extenders would have on beneficiaries and the providers on which they depend. Below is a list of provisions that that have been addressed by Congress in the past.

Active Policies

- **Extension of improved payments for low-volume hospitals** - Applies a percentage add-on for each Medicare discharge from a hospital more than 15 road miles from another like-kind hospital[10] that has fewer than 1,600 Medicare discharges during the fiscal year. The estimated cost is approximately $400 million per year in 2016 and 2017.
  - *Expires: October 1, 2017.*
- **Extension of Medicare Dependent Hospital Program** - Extends the designation to rural hospitals with fewer than 100 beds, not classified as an SCH and having at least 60% of inpatient days or discharges covered by Medicare. The estimated cost is approximately $200 million per year in 2016 and 2017.
  - *Expires: October 1, 2017.*
- **Extension of ambulance add-ons** - Implements a bonus payment for ground and air ambulance services in rural and other areas. The estimated cost is approximately $100 million per year in 2016 and 2017.
  - *Expires: January 1, 2018.*
- **Extension of exceptions process for Medicare therapy caps** - Extended the process allowing exceptions to limitations on medically necessary therapy. The estimated cost is approximately $800 million and $600 million per year in 2016 and 2017 respectively.
  - *Expires: January 1, 2018.*
- **Extension of the work geographic index floor under the Medicare physician fee schedule** - Applies a floor on geographic adjustments to the work portion of the fee schedule, with the effect of increasing practitioner fees in rural areas. The estimated cost is approximately $400 million per year in 2016 and 2017.
  - *Expires: January 1, 2018.*

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[10] This applies only to "subsection (d) hospitals" - Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

Expired Policies

- **Extension of outpatient hold harmless provision** - Extends the outpatient hold harmless provision for those rural hospitals and Sole Community Hospitals ("SCHs") with 100 or fewer beds. The estimated cost is approximately $200 million over ten years for a one year extension.
  - *Expired: December 31, 2012 for rural hospitals and SCHs with no more than 100 beds. It expired March 1, 2013 for SCHs with more than 100 beds.*
- **Hospital wage index improvement** - Extends reclassifications under Section 508 of the Medicare Modernization Act (P.L 108-173).
  - *Expired: March 31, 2012.*
- **Extension of payment for the technical component of certain physician pathology services** -- Allows independent laboratories to bill Medicare directly for certain clinical laboratory services.
  - *Expired: June 30, 2012.*
- **Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities** - Extended Sections 114(c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007.
  - *Expired: June 30, 2012.*
- **Extension of physician fee schedule mental health add-on** - Increased the payment rate for psychiatric services delivered by physicians, clinical psychologists and clinical social workers by 5 percent.
  - *Expired: February 29, 2012.*
- **Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas** - Reinstated the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals.
  - *Expired: June 30, 2012.*
- **Extension of Community Health Integration Models** - Removed the cap on the number of eligible counties in a State. .
  - *Expired: September 30, 2012.*

July 27, 2015

Honorable Kevin Brady
Chairman, Health Subcommittee
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Honorable Jim McDermott
Ranking Member, Health Subcommittee
House Ways and Means Committee
1106 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of America's Critical Access Hospital Coalition, I respectfully submit to you written testimony for the hearing on July 28, 2015, to discuss rural health care disparities created by Medicare regulations. America's Critical Access Hospital Coalition is comprised of more than 150 CAHs across the country that brings together healthcare leaders to develop innovative, sustainable practices and plan for the future of healthcare in rural America.

Thank you for you providing the Coalition the opportunity to express several of its concerns. We look forward to working with you.

Sincerely,

Paul Lee
Senior Partner and Founder
Strategic Health Care

cc: House Ways and Means Committee, Subcommittee on Health Members

Testimony for Submission

Before the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Hearing Entitled

"Rural Health Care Disparities Created by Medicare Regulations"

July 28, 2015

Teladoc 2 Manhattanville Road, Suite 203 + Purchase, NY 10577

P (203) 742-1719 **F** (203) 769-1544 + www.teladoc.com

Chairman Brady and members of the Subcommittee, thank you for holding this important hearing on rural health and for the opportunity to submit written testimony for the record.

Background

Teladoc was founded in 2002 with the goal of improving and broadening access to health care professionals while enhancing quality and decreasing costs. The company is the first and largest company providing primary care telehealth consultations in the United States. Teladoc's physicians serve over 11 million members and it is anticipated that they will conduct more than five hundred thousand unique visits this year. Teladoc provides 24/7/365 access to affordable, high quality medical care via interactive audio and audio-visual technology. Teladoc deploys its network of over 1100 board-certified physicians and behavioral health professionals to address simple non-emergent medical conditions.
Industry experts, payers and most importantly, individual consumers have embraced Teladoc as a convenient, affordable way for patients to access healthcare services. Our services are available to individuals primarily through their employer- or association-sponsored health benefit plans. Our clients include health plans, large and small employers, hospital systems, unions, and state health plans.

All of the doctors in Teladoc's network are U.S. board-certified family practitioners, emergency room physicians, pediatricians and internists who use electronic health records to diagnose, treat, and write prescriptions when necessary. Our quality process meets National Committee for Quality Assurance (NCQA) standards. Teladoc physicians provide care while adhering to our set of 110 proprietary, evidence-based clinical practice guidelines for the treatment of common uncomplicated medical conditions using audio video or interactive audio with asynchronous store and forward technology.

Telehealth is safe. 100% of the time, patients using Teladoc's physician network must provide a complete medical health record through the telehealth platform, often times supported by the medical history provided by the patient's health plan. The physician must review the data before the real time visit

is arranged. In the practice of traditional cross coverage, the covering physician may not have access to the patient's Electronic Medical Record (EMR). The standards and quality of care for patients treated through telehealth is at least equal to and sometimes greater than that of an in-person encounter.

Telehealth saves the system money. A Teladoc visit is just 30% of the cost of a traditional primary care physician visit, 25% of an urgent care visit and only 2.5% of an emergency room visit. The cost savings to patients, employers, Medicare and Medicaid is substantial. As an additional benefit, there is a significant reduction of unnecessary emergency room visits, improving access for true medical emergencies.

Telehealth is responsible for curbing health care costs and increasing positive patient outcomes and satisfaction within the health care system. New data released by the University of Rochester Medical Center found that telehealth eliminated nearly one in five emergency room visits[1].

A study released in February 2015 by Veracity Healthcare Analytics found that the use of Teladoc's services among beneficiaries of one of the nation's largest employers was associated with a significant reduction in per member per month spending, in part as a result of reduced office visits, emergency room visits and hospitalizations[2]. A separate analysis prepared for Teladoc by Red Quill Consulting[3] found that the average cost of a telehealth visit is substantially lower than a visit for in-person acute care and that, even in Medicare where telehealth visits are reimbursed at the same rate as in-person care, the Medicare program would achieve significant savings by offering telehealth services more

[1] Orr, Leslie, "Is Telemedicine a Viable Alternative to Ambulance Ride and ER Visit?," June 11, 2015.
[2] Choudhry, N., Milstein, A., Gagne, J., "Impact of Teladoc Use on Average per Beneficiary Per Month Resource Utilization and Health Spending," Veracity Healthcare Analytics, February 2015.
[3] Yamamota, Dale H., "Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services," December 2014.

broadly. That same analysis found that even a modest amount of increased utilization – because of the introduction of telehealth services – would not offset these Medicare savings[4].

Telehealth provides more options for patients to access care. The use of telehealth is particularly important to rural areas – approximately half of Teladoc's patients reside in rural areas. Moreover, telehealth is an effective way to provide timely access to those who travel frequently or who may not have the flexibility to access a physician's office during regular business hours. It is a health care service for which there is growing consumer demand.

Telehealth provides routine medical care. Interactive audio using asynchronous store and forward technology and audio-video medical consults conducted by experienced primary care physicians appropriately address routine, acute, non-emergent, non-recurrent medical conditions with marketplace receptivity for its merits in addressing minor issues. In researching possible methods for nurse telephone, triage for interventions, some large health plans have identified nearly 5000 clinical scenarios and 320 symptoms from which an intake nurse can choose. After further questions, approximately 15 ultimate scenarios may arise from any one symptom. Experience has determined that there are about 550 clinical scenarios as candidates for telehealth consultations; 120 of these scenarios may be appropriate for physician intervention instead of or in addition to a nurse.[5] Some examples include:

- Respiratory Infections
- Gastroenteritis
- Sinusitis
- Bronchitis
- Urinary Tract Infections
- Pharyngitis
- Seasonal Allergies

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[4] Yamamota, Dale H., "Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services," December 2014.

[5] Gingrich, Newt; Boxer, Richard MD; Brooks, Byron MD; Telephone Medical Consults Answer the Call for Accessible, Affordable and Convenient Healthcare; Center for Health Transformation, Washington, DC; 2008

- Prescription refills as appropriate for the short-term, excluding controlled

Government Program Barriers

In recent years, the use of telehealth entered the mainstream of health care delivery for primary care. Commercial payers, employers and consumers have embraced telehealth as a convenient, efficient, and cost-effective way to provide primary care services. Unfortunately, government programs such as Medicare have been slow to embrace telehealth services. In fact, government rules and regulations pose significant barriers that prevent Medicare and Medicaid beneficiaries, veterans and others from accessing telehealth services.

Medicare beneficiaries have had much more limited access to telehealth services because federal telehealth policies are out of date. Reimbursement is only available for a limited range of Medicare Part B services. Reimbursement also is available only when live video is substituting for an in-person visit, and does not extend to asynchronous store and forward technology except in a limited number of federal telehealth demonstration projects. Moreover, telehealth is covered in Medicare only when originating in a limited setting when a site is operating in a health professional shortage area, a demonstration program in Alaska and Hawaii, or a country outside a metropolitan statistical area.

Recommendations for Removing Barriers

We strongly believe that acute care telehealth services should be billable under the Healthcare Common Procedure Coding System where such services would have been reimbursed as medically necessary care in an in-office setting or other physical setting under Medicare. We also believe that barriers to telehealth services should be removed so that Medicare beneficiaries with chronic conditions can have expanded access to remote monitoring services, especially if they are part of a care network within a Medicare Advantage plan setting, Accountable Care Organization, Patient-Centered Medical Home or other form of coordinated system within the program.

Specifically, Teladoc would recommend that the Committee consider the following changes to the Medicare program:

1) revise Medicare policy so that physicians need not be required to be physically present for telehealth services to be reimbursed under Medicare;
2) allow reimbursement under Medicare for telehealth services without requiring that such services originate from a statutorily or regulatorily defined specific site of care; and
3) waive Medicare origination site fees for providers of telehealth services.

These changes would go a long way to expanding access to care, helping reduce Medicare costs, and improving services for beneficiaries with chronic conditions.

Providing more broad-based access to Medicare beneficiaries not only would create a better patient experience for seniors, but would reduce emergency room visits and prevent getting non-emergency care in more expensive care settings. As Baby Boomers continue to enter the Medicare system, they will already be accustomed to utilizing technology for their care delivery and management. Some examples of how Teladoc can alleviate cost pressures and enhance quality in the Medicare program include decreasing emergency room visits for non-emergent care, improved access to medical care by removing the disparities in access between rural and urban area and decreased costs for both the program and the patients.

For seniors with transportation or mobility challenges, the ability to access the healthcare system from home will allow this group to maintain their independence and to seek medical help without the inconvenience of arranging travel. Currently, without access to Teladoc, seniors are forced to wait for availability with their physician and physician's offices are backlogged with these visits limiting their

ability to see additional patients and make up cost deficiencies with volume. From a safety and continuity of care perspective, complications that might arise from delayed access to a physician, exacerbate the issue and are another factor that increase costs and decrease quality of life for seniors.

Conclusion

Teladoc would welcome the opportunity to meet with the members of the Committee to further discuss telehealth, our company and our policy recommendations. We appreciate the Subcommittee's focus on issues related to rural health and look forward to working with you in the future.

WISCONSIN HOSPITAL ASSOCIATION, INC.

Statement of the

Wisconsin Hospital Association

before the

Committee on Ways and Means of the

U.S. House of Representatives

"Rural Health Disparities Created by Medicare Regulations"

Tuesday, July 28, 2015

On behalf of our more than 140 member hospitals and health systems, including many small and rural hospitals, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on rural health disparities created by Medicare regulations.

By way of background, Wisconsin hospitals and health systems are nationally known as innovators and deliverers of high "value" care – high quality, cost efficient care. Wisconsin's rural prospective payment system (PPS) and Critical Access Hospitals are equally committed as their larger suburban and urban counterparts to providing high value care. In fact, Wisconsin was ranked the second most highly-rated state in the country based on the quality of its health care according to the federal Agency for Healthcare Research and Quality (AHRQ). Wisconsin had the second best overall health care quality measure score among all 50 states based on more than 200 measures that AHRQ used to evaluate health care performance. The rankings are posted here: http://nhqrnet.ahrq.gov/inhqrdr/state/select. Results like these have been confirmed by others including the Dartmouth Atlas, Kaiser Family Foundation and The Commonwealth Fund and equate to benefits for both the Medicare program and Medicare beneficiaries.

Proactive Commitment To Quality, Value

A few examples of the proactive work of Wisconsin hospitals are CheckPoint, PricePoint and Wisconsin's Partners for Patients initiatives. These are projects in which virtually all Wisconsin hospitals, including rural PPS and Critical Access Hospitals, participate.

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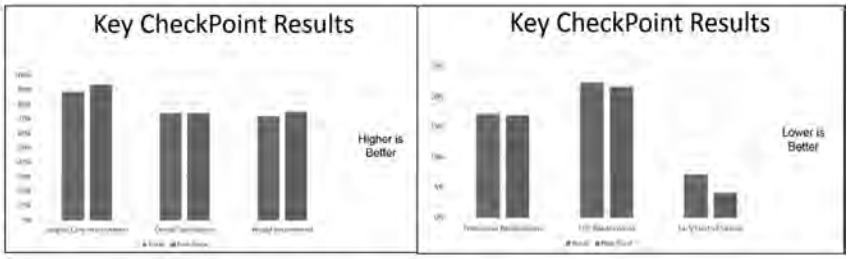
- **Wisconsin's CheckPoint: First Voluntary Quality Public Reporting Site in Nation** – health care quality work in Wisconsin is grounded in measurement and transparency. WHA launched CheckPoint (www.WiCheckPoint.org) in 2004, the first voluntary hospital quality public reporting site in the nation. For over a decade, CheckPoint has promoted health care transparency by collecting and reporting information to help consumers make informed decisions about their hospital care. The mission of CheckPoint is to develop consumer-focused initiatives that provide reliable, valid measures of health care in Wisconsin to aid the selection of quality health care and quality improvement activities within the hospital field. Virtually every hospital in Wisconsin participates in CheckPoint, including reporting on over 50 outcome (eg: readmissions, infections, mortality), process and satisfaction (HCAPS) measures. Unlike quality reporting efforts in other states and even at the national level, **Wisconsin's CAHs participate in CheckPoint. Below are several examples of rural and urban outcomes on CheckPoint measures.**



- **Wisconsin Partners for Patients** – the vast majority of Wisconsin hospitals participated through WHA's "hospital engagement network" (HEN) in this national initiative. This means Wisconsin's hospitals are working collaboratively to address key quality and patient safety issues, including reducing readmissions, preventing hospital-associated infections, decreasing adverse events and reducing the number of babies delivered before 39 weeks. Our hospitals, including rural PPS and CAHs, had the following outcomes between 2011-2014 from their work:

  - 98% of Wisconsin CAHs participated in these collaborative initiatives
  - 20% reduction of readmissions
  - 40% reduction of patient harm
  - Wisconsin health system cost savings for Medicare program totaled **$87,094,000**
  - Potential patient harm reduced for **9,304 Wisconsin patients**

  Access information on these impressive efforts at: http://www.wha.org/quality.aspx

- **Wisconsin's PricePoint** – PricePoint is Wisconsin's price transparency website supported by the work of the WHA Information Center (WHAIC). WHAIC is dedicated

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to collecting and disseminating complete, accurate and timely data about charges and services provided by Wisconsin hospitals and ambulatory surgery centers. WHAIC has been collecting and reporting data since 2003. An updated, more consumer-friendly version of the website was recently launched. All of Wisconsin hospitals participate in PricePoint, another testament to their proactive efforts to providing meaningful information to the public. Access the website at http://www.wipricepoint.org

We believe these are several examples of our hospitals' commitment to increasing value to patients, employers and payers, including Medicare. Wisconsin's rural PPS and CAHs are just as dedicated to these efforts as any other facility.

Medicare Policies and Their Impact on Rural Care

Despite our state's aggressive commitment to improving quality and value, Medicare policies can and do pose roadblocks to maintaining access to care in rural communities. WHA respectfully recommends addressing the following key CMS policies:

- **Harmonize Conflicting "96 Hour" Rules For CAHs** – In sub-regulatory guidance stemming from the two midnights policy in the FY 2014 PPS final rule, CMS stated that, as a condition of payment, physicians at critical access hospitals (CAHs) must certify that a beneficiary may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH. If a physician cannot certify the reasonable expectation that a Medicare beneficiary will be discharged or transferred within 96 hours, then Medicare Part A payment is inappropriate. This guidance appears to have brought to the foreground an apparent conflict in two 96 hour rules. WHA believes the differing 96 hour rules stem from the 1999 Balanced Budget Refinement Act (BBRA), which made important improvements to the CAH program, including establishing the 96 hour annual average for patients in order to participate in the Medicare program. However, the BBRA does not appear to have appropriately cross-referenced the corollary payment statute as well and left 96 hour limit (*not* an annual average) under its Conditions of Payment.

  Unless these two 96 hours are harmonized, access to care that should be delivered locally will be denied for numerous Medicare patients in rural America, forcing care further away to non-local facilities. This policy creates a barrier to care that legitimately can be provided in rural hospitals. It also places an arbitrary time-based barrier in the physician-patient relationship. It does so by requiring a physician at a CAH to certify that each Medicare patient will be discharged or transferred within the 96 hour window. Situation where this CMS policy could increase rural disparities for care include: managing chronic diseases, pneumonia, other respiratory issues and certain procedures. The patients may be forced to travel longer distance to a hospital outside of their community or they may choose not to seek care at all. **WHA and our rural, Critical Access Hospitals strongly support harmonizing these 96 hour rules, as contained in HR 169, the Critical Access Hospital Act, currently pending in the U.S. House Ways & Means Committee.**

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- **Allow For More Flexibility In "Direct Supervision" Rules** – Beginning in 2009, CMS introduced the concept of "direct supervision" with some commentary in Open Door Forums. That commentary stated the physician must be "physically present" in the outpatient therapy department. While the requirement was referred to a "clarification," it was actually a fairly drastic change in policy without clinical rationale or evidence that quality of care or patient safety had been compromised in hospital outpatient departments. Further, the policy contradicted Medicare Conditions of Participation for CAHs. As a result, hospitals found themselves at increased risk for unwarranted enforcement actions for care they are qualified and capable of providing. Although CMS has implemented some smaller modifications to this policy, it is in force at the current time.

  WHA believes the change was unwarranted and will be particularly problematic for rural hospitals' ability to provide Medicare beneficiaries with access to certain outpatient therapeutic services. WHA also believes it is important to raise the point that rather than traveling to other hospitals for their care, many rural Medicare beneficiaries may choose instead to *not* seek care if that care is not locally accessible. As we are certain the Committee is aware, delayed care causes more medical issues for patients, less preventative care and higher costs to the Medicare program. **For these reasons, WHA supports bipartisan legislation – HR 1611, The Protecting Access to Rural Therapy Services (PARTS) Act – currently pending in the U.S. House Ways & Means Committee.**

- **Two Midnight Policy/Recovery Audit Contractors** – The onset of the Recovery Audit Contractor (RAC) program several years ago has had a variety of unintended consequences, one of which revolves around inpatient versus observation stays. This issue is the direct result of the RAC focus on denying Medicare payment for shorter inpatient stays because the RAC deems, post-fact, that care should have been provided in the outpatient setting (regardless of the fact care was medically necessary). A corollary CMS policy effective throughout much of the existence of the RAC program has been to essentially deny hospitals the ability to rebill (Medicare Part B) for these medically necessary services (note: this is the subject of pending litigation.) The ensuing confusion over RAC denials has resulted in some uptick in the number of patients put into what is known as "observation status." Unfortunately, the solution CMS put forth in its FY 2014 Inpatient Prospective Payment System Rule to this issue, over objections from the hospital field, was a multi-part policy known as the "two midnight" rule.

  Under the original two midnight policy, a time-based benchmark for inpatient admissions was created. The benchmark indicates physicians (or other qualified individuals) should admit a patient if he/she expects care to span at least two midnights. Second, it set forth criteria for physician orders, certification and documentation that must be included in the medical record in support of medical necessity and that inpatient admission was appropriate. Third, the policy provided a general presumption for external review contractors (like the RACs) that care spanning more two midnights should be presumed appropriate for inpatient admissions and Part A payment criteria are met. At the time the two midnight policy was released by CMS, the hospital field, including rural and CAHs,

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expressed concerns that the policy was placing an arbitrary, time-based criteria into the physician-patient relationship. Fortunately, Congress understood the depth of problems this CMS policy created and legislatively delayed *enforcement* (ie: RAC recoupment efforts) of it through September 30, 2015. Unfortunately, Congress did not stop or adjust the policy itself, which is still in effect.

Due to the policy's problems, MedPAC recently recommended the policy's repeal. CMS has yet to do so. Instead, in its proposed CY 2016 OPPS rule, CMS would adjust its policy for stays spanning less than two midnights. In these instances, inpatient payment would be appropriate on a "case by case basis" based on the medical judgment of the admitting physician. CMS also proposes removing Recovery Auditors and Medicare Administrative Contractors from the first line medical review for these shorter stays and has initial reviews of stays less than two midnights done by Quality Improvement Organizations (QIO). CMS is proposing no changes to the two midnight policy for stays spanning longer than two midnights.

Overall, WHA believes CMS' proposed modifications as discussed above are valuable, but still do not address the underlying problems that created this situation—overzealous RACs. The two midnight policy was just one downstream impact caused by the Recovery Audit program, but there are others. WHA believes CMS needs to do more to fix the problems with this program and, therefore, supports legislation – the Medicare Audit Improvement Act (HR 2156) pending in the House Ways & Means Committee – that would do so.

Finally, WHA wants to reiterate the unique circumstances of rural PPS and Critical Access Hospitals in states like ours. These facilities are the rural health care infrastructure in Wisconsin and across the nation and WHA continues to strongly support the Critical Access Hospital program designation as well as key Medicare policies for rural PPS hospitals known as "Medicare Dependent Hospitals" and "Low Volume" hospitals. As CMS and Congress look at Medicare program policy, WHA asks it to keep the following in mind with respect to small, rural hospitals:

- Congress created the **Critical Access Hospital designation in 1997** as hundreds of small hospitals closed due to their inability to financially survive under Medicare's prospective payment system. Due to their small size and fluctuating patient mix, CAHs needed more stability in payments in order to survive. **The alternative payment model used by Medicare for CAHs has allowed stability and access to care for some 60 million rural residents who are scattered over 90 percent of the nation's landmass.**

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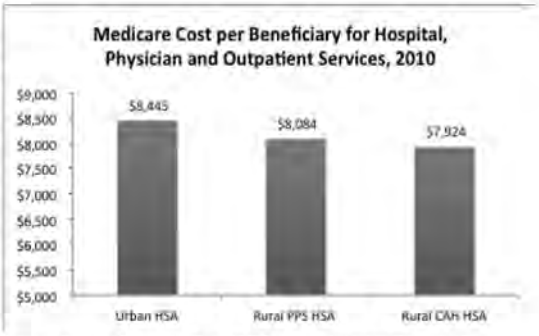
- States with CAHs are providing cost-effective care for Medicare. For example, Medicare spending in Wisconsin is lower for rural than urban $6,424 (rural) $6,706 (urban) (source: iVantage). Further, other sources confirm that rural PPS and CAHs provide cost efficient care, as seen in these two charts.



Source: Dartmouth Atlas of Healthcare, 2010 Medicare reimbursements per enrollee.

Total Medicare (Part A & Part B) Reimbursements per Enrollee

	Reimbursement/Enrollee	Commonwealth Fund Rank	# CAHs
Hawaii	$5,311	1	9
Iowa	$6,572	7	82
Montana	$6,340	5	48
New York	$9,564	51	13

Source: http://www.rwhc.com/Portals/0/papers/CAH%20Values%20Final%202%2013.pdf

- Rural populations tend to be older, sicker and poorer than individuals in urban areas. In fact, the Department of Health and Human Services states, "rural areas have higher rates of poverty, chronic disease, and un-insurance, and millions of rural Americans have limited access to a primary care provider." While 20 percent of the population lives in rural America, only nine percent of physicians practice in rural areas. Seventy-seven percent of the 2,050 rural counties in the U.S. are primary care HPSAs. More than 50 percent of rural patients have to travel 60 miles or more to receive specialty care. (source: NRHA). Additional flexibility for rural Graduate Medical Education opportunities is also an area where CMS policy could be improved.

In closing, Wisconsin hospitals have a strong and long-standing commitment to collaboration and the pursuit of high value care—high quality, cost efficient care. This pursuit is shared by all of Wisconsin's facilities, regardless of size. WHA and our hospitals stand at the ready to assist Congress and CMS in developing approaches that continue moving Medicare further along the health care value continuum while still recognizing the unique roles rural PPS and Critical Access Hospitals play throughout our state and much of the country.

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